COMMUNITY PARTICIPATION IN HEALTH AND FAMILY WELFARE:

INNOVATIVE EXPERIENCES IN INDIA

A Guide for Health Administrators and Professionals for Community Health and Development

Dr Ashok Sahni
Professor and Hony Executive Director

Dr Sudha Xirasagar
Faculty Research Associate

1990

INDIAN SOCIETY OF HEALTH ADMINISTRATORS (ISHA)
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PREFACE

Since 1938, when a Sub-Committee was appointed at national level, to implement the recommendations of the International Conference in 1937, at Bandung, Indonesia, great degree of stress has been laid on community involvement and participation to provide effective health services. Various national committees, the Five Year Plans, and National Health Policy in 1983, have emphasized the importance of community participation. The VIIth Five Year Plan proposed community participation as one of the five strategies, for Primary Health Care. The draft VIIIth Five Year Plan has again strongly emphasized the importance of community participation and proposed action plans for implementation.

With the beginning of the First Five Year Plan, specifically from October 2nd, 1952, attempts were made in community cooperation and establishment of cooperatives in the agricultural sector. Several programmes at the national level, both in the government and voluntary sectors, have been initiated in the health and family welfare field. Some case studies have been published sharing the experiences of these projects by the administrators and researchers. However, no comprehensive study has been undertaken to identify the process factors contributing to the effectiveness or ineffectiveness of community participation.

The World Health Organization has played an important role in the promotion of community involvement in health development. Studies have been conducted, since the late 1970s, in several countries and inter-country training programmes organized to share experiences in community participation.

Community participation is an essential component for effective planning and implementation of the Primary Health Care strategy towards Health For All by 2000 AD and beyond. Towards this objective, Indian Society of Health Administrators, felt it essential to study the innovative community participation projects so that the leaders and administrators at various levels could use the learnings for effective planning and implementation of the health and family welfare programme. The learnings could also be used for training and development of administrators.

We are grateful to the Indian Council of Medical Research for providing a small grant to study some of the projects and for the permission to bring out this publication. We are also grateful to several organizations for financial contributions to meet with partial printing expenses of the publication.

We hope this publication will serve as a guide to the present and future administrators and professionals in planning and implementing programmes for community participation towards health and development of the community.

Dr Ashok Sahni
Professor and
Hony Executive Director

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CHAPTER - I

TOWARDS COMMUNITY PARTICIPATION AND HEALTH CARE IN INDIA

This chapter reviews briefly the historical development of the concept of Community Participation in India; the emphasis given to community participation in the Policy and Plannning Documents; and the importance of community participation in Primary Health Care towards achieving the goal of Health For All.

Introduction

1. Community participation in health is as old as community life itself. The mothers and grandmothers, traditional medicine practitioners, healers, bonesetters and massage specialists have been taking care of the community and even today a good proportion of illness is handled by them. The traditional birth attendants, mothers, and kindly neighbours have been giving the antenatal,intranatal and postnatal care. With the advent of modern medicine and its technology orientation, health and medicine came to be regarded as the domain of the medical professionals; and the paramedical personnel and the community came to be regarded as the passive recipient of the services provided by technically qualified personnel.

2. It is now well-accepted that majority of the diseases and mortality are related to lifestyles and practices which are deeply rooted in the community. Prevention of many diseases requires changes in behaviours, living conditions, and in many cases, requires community based actions and cooperation. Examples include, ensuring the availability of potable drinking water and using it, protection of these sources from sullage; environmental sanitation, personal hygiene and maintaining good nutrition. Thus, more and more it has been realized that medical technology is not the answer for more than 80% of the health problems of the vast majority of the people dwelling in towns, villages, hamlets and forests. Also, health needs are not met merely by establishing primary health centres and subcentres. Unless the community is involved, no amount of sheer financial investment can result in health of the people.

B. Evolution of the Concept of Community Participation in India

3. As early as 1937, these concepts were embodied in the recommendations of the International Conference at Bandung organized by the League of Nations,Pandit Jawaharlal Nehru, as member of the Executive Committee of the Congress Party attended the Conference. The focus of the Conference was on the widespread prevalence of and high mortality due to preventable diseases caused by poverty, ignorance and unhygienic conditions in large populations of the developing world. The Conference recommended, as a major strategy, health education of people living in remote,inaccessible areas, through people trained in some basic health concepts. By this strategy the conference hoped, substantial suffering and death could be avoided, and also the active participa

tion of the community could be enlisted for the planning and management of the health programmes. In fact, considering even the task of carrying health education to the millions, the Conference observed that the medical and nursing personnel cannot by themselves undertake this mammoth task. They would need to enlist community participation for such massive nationwide health education efforts.

4. The Bhore Committee was appointed in 1945, by the colonial Government of India to draw up a detailed scheme of a feasible health system for India. The committee endorsed the recommendations of the Bandung Conference, keeping in view the very economics of the health education as a strategy for disease control. This was followed by the Mudaliar Committee Report which again stressed on community involvement for effective health care.

5. Importance of community participation and cooperation for the success of any health or developmental programme was realized by the Government of India immediately after Independence. Realizing the critical importance of agricultural and economic development, community cooperation and participation programmes were initiated in the first Five Year Plan under the leadership of Shri S K Dey, Union Minister of Agriculture and Cooperation. On October 2nd 1952 (birthday of Mahatma Gandhi), Community cooperation programmes were started along with Primary Health Centres.

6. It was presumed that governments and government machineries could implement the programmes and thereby bring about health in the community. However, in addition to the importance of activities connected with implementation, community education and acceptance of the measures came to be increasingly recognised as a key factor for the success of a public health programme. Even seemingly administrative measures, like domestic insecticidal spraying for vector control as part of the malaria control programme, needed not only community acceptance, but also supplementary community measures to destroy vector-breeding sites in the neighbourhood of successful malaria control. In other crucial areas, individual measures adopted on a community-wide scale, like good nutrition, housing and hygienic habits became critical factors in disappearance or reduction of diseases like tuberculosis and leprosy in developed countries.

7. A clear worldwide commitment to community participation as an essential component of any health care delivery system, emerged in 1978 when Governments of 108 Member -Countries of the World Health Organization became signatories to the Alma-Ata Declaration, pledging to make Primary Health Care available to all their citizens with the full participation of individual families and communities for health development.

C. Why Community Participation?

8. Community participation is recognized to be the essential strategy to provide Primary Health Care for several reasons:

(i) 65% to 85% of all health care is actually self-care, or care by the families, and it has tremendous potential to be suitably modified in keeping with modern health knowledge which would be highly cost-effective.

(ii)On an ideological level, the participation of the individual, the family and the community, and, the measure of self reliance, that ensues, would satisfy the need for identity and self-fulfillment.

(iii) At a practical level, given the task of extending primary health care to an additional 80% of the population, the underserved and unserved sections, with no corresponding increase in material resources, one must look for an alternative resource. The development of human resources in the community was thus initiated as a strategy, on a global scale, to meet the challenge of providing primary health care.

9. The concepts of Primary Health Care, community participation and health development, have evolved in parallel with the evolving concept of development.It is widely recognized that development does not result from merely pouring in investment and exploitating the natural resources. Even improvement of certain economic indicators, like GNP, are often highly deceptive since it may be accompanied by impoverishment and deterioration of quality of life for large number of people. An increase in GNP, makes little sense if large number of citizens are living in subhuman conditions suffering from overwhelming poverty, morbidity and mortality, much of which is preventable by a more equitable access to resources including health care. In fact, in India ,as in many developing countries, the health scenario exactly reflects this pattern. Rising health budgets and increasing sophistication of medical technology have been achieved, yet the vast majority, particularly the rural and urban poor continue to suffer from much preventable morbidity and mortality.

10. Development,including health development,results from full participation of the community in the process, i.e. the development of its human resources to ensure a fair distribution of the benefits. Thus, primary health care is charged with the goal of health development - increase in well-being of all, and not merely, multiplication of medical facilities or an increase in resource allocation, or a statistical improvement of national morbidity indicators.Health development cannot take place unless there is community participation in laying down the priorities, planning, implementation and evaluation of the health programmes.

D. Intersectoral Collaboration

11. Evidence has been mounting that intervention through health programmes alone cannot produce much impact unless other sectors of community life are also impacted. The favourable influence of high female literacy rates in Kerala State and Sri Lanka on population growth rates has been hailed at national and international forums. In the Five Year Plan documents and in India's Health policy spelt out in 1983, it has been repeatedly affirmed that intersectoral cooperation is an urgent need if we are to improve the health status in the country. The importance of agricultural productivity,provision of sources of potable drinking water, supplementary income generation for the rural and urban poor are obvious.

12. The Government of India in the Seventh Five Year Plan stressed that, in the success of health and Family Welfare Programmes, the single most important factor is the active participation and involvement of the people, non-government organizations, and community organizations.

It was a matter of great concern that in spite of massive increases in budgetary allocations for health from the First Five Year Plan to the Seventh Five Year Plan (when it amounted to 3% of the Gross National Product), even though considerable progress has been made in expanding health facilities and manpower in every nook and corner of the country, the progress in terms of improving the status of general health and family planning acceptance, have not been as per expectations. Planners and administrators, as well as field workers, in health are concerned with the lack of community participation in government health programmes.

E. Community Participation and Eighth Five Year Plan

13. The Policy and Perspectives Document for the Eighth Five Year Plan 1990-95, prepared by the Working group on Health Care Delivery of the Planning Commission, has again stressed the importance of community involvement and participation through village health committees in every village. The Document stresses that the community should be involved right from the stage of planning to implementation of the programmes.

The Document makes the following recommendations to encourage community participation.

a. The Community in the village should be organized to form village health committees with representatives from "Women's Organizations, SC/STs", and other associations, and known leaders.

b. Now that the Village Panchayats are being given responsibilities, they should be involved in the concept of village health guides scheme through village health committees.

c. Block and District level Panchayats should be fully involved in planning, organizing and delivering the health services on the pattern of Maharashtra and Gujarat. The same should be put into practice in other states/union territories.

F. Community Participation for HFA

13. The targets in health and family welfare to be achieved, if we are to achieve our Goal of Health For All by 2000 AD, are as shown in the table:

GOALS FOR HEALTH AND FAMILY WELFARE

Sl No	Indicator	Current Level Except NRR and Growth Rate Rate per 1000)	Goals		
			1985	1990	2000
1	2	3	4	5	6
1.	Infant Mortality Rate	Rural 136 (1978)	122	--	--
		Urban 70 (1978)	60	-	--
		Total 125 (1978)	106	87	below 60
	Perinatal Mortality	67 (1976	-	--	30-35
2	Crude death Rate	around 14	12	10.4	9.0
3	Pre-school child (1-5 yrs) Mortality	24(1976-77)	20-24	15-20	10
4.	Maternal Mortality Rate	4-5 (1976)	3 - 4	2 - 3	below 1
5	Life Expectancy at birth(Years)	Male 52.6(1976-81)	55.1	57.6	64
		male 51.6(1976-81)	54.3	57.1	64
6	Babies with below 2.5 Kg(%)	30	25	18	10
7.	Crude birth rate	around 35	31	27.0	21.0
8.	Effective Couple Protection (%)	23.6(March 82)	37.0	42.0	60.0
9.	Net Reproduction rate (NRR)	1.48 (1981)	1.34	1.17	1.00
10	Growth Rate(Annual)	2.24(1971-81)	1.90	1.66	1.20
11	Family Size	4.4(1975)	3..8	--	2. 3
12.	Pregnant Mother receiving antenatal care (%)	40-50	50-60	60-75	100
13.	Deliveries by trained birth attendants(%)	30-35	50	80	100

14 .Immunization Status
(% Coverage):

T T (for pregnant women)	20	60	100	100
T T for School Children				
10 years	--	40	100	100
16 years	20	60	100	100
DPT(Children below 3 years)	25	70	85	85
Polio(Infants)	5	50	70	85
BCG (in ants)	65	70	80	85
DT (new school entrants 5-6 years)	20	80	85	85
Typhoid (new school entrants 5-6 years)	2	70	85	85

14 Agains the above background, the process of community participation needs to be studied with regard to the dynamics of community participation, and the results of community participation in terms of achievements of these health goals in project areas. Besides, what were the dynamics of multisectoral involvement as related to health? Worthwhile learnings from experimental project areas need to be applied to Government Health Programmes to utilize our limited resources effectively and provide equitable health care

CHAPTER - II

WHAT IS COMMUNITY PARTICIPATION?

What is community participation? Many attempts have been made to explain the nature and process of community participation. Is community participation same as community involvement or community cooperation? This chapter examines the nature and process of community participation in the light of the above questions.

With the need to mobilize the community to participate in primary health care, employing as change agents an existing health manpower oriented to curative, hospital-based, technology-oriented services, and in a wide variety of contexts, different levels of community participation have been achieved depending upon the community factors, the change agent factors, and the material resources available. These can be classified as follows:

Model-I . At one end of the spectrum, the health agency (voluntary or governmental) offers curative services which is a felt need of the community. Through this entry-point, health education is also introduced into the community, and thus, the community is persuaded to accept the preventive-promotive and family welfare services, essentially provided by the agency itself. Wherever community cooperation is required, e g coverage for immunization or indoor insecticidal spray, it is now forthcoming.

At this level though community participation is evident, self-reliance is the least apparent. In all likelihood, if the agency terminates its activities in the area, primary health care would go back to the preproject state

Model-II. At the next higher level of community participation, the agency starts operating curative services for the community as an outreach service. Through satisfaction of this felt need of the community, and through health education of the community leaders, the agency draws the participation as follows: The agency offers to provide technical and organizational inputs, with or without inputs like drugs and equipment, to set up a health/medical centre, on the condition that the community donates land or building or some equipment.

In this case, although the community involvement is greater than the first model, it would be noted that mostly, this is the participation of few community leaders or a few affluent persons rather than the entire community. The dependence on the external agency is still considerable and most likely, if the agency withdraws, health care will more or less go back to the pre- project level. Even at this stage, the participation of the community is still marginal and transitory . The involvement of the people has little direct influence on the outcome of the health programme.

Model-III. At the third level, the community to some extent participates on a slightly more wide-spread basis. This is most evident in the health cooperatives, wherein due to higher community awareness of the need for services, the community on a continuing basis, funds the health programme. In this model, the initiative to provide health care, organize, administer and maintain the health cooperative activities remain largely the responsibility of the agency, and there-

fore the community is still largely dependent upon the external agency for the continuation of primary health care. However, the level of health education inputs that has been put into the community to bring forth this amount of involvement and cooperative spirit, is also likely to mobilize the community to actively seek primary health care services through other sources,in case the agency withdraws from the area.

This is a measure of self-reliance in health, built up in the community as a result of the agency's intervention.

Model-IV. At the next level, community participation in its fullest sense is realized i e participation in planning, implementation and evaluation of the health services, tailoring it to local needs mostly relying on local resources, including the human resources required for primary health care Briefly the process would involve the following steps:

a) Training of community based catalystic agent by the heath agenc -the community worker could be either paid multipurpose worker, or voluntary village health workers/guides.

b) Stimulated by the catalyst, the community identifies its problems and its felt needs.

c) The formal and informal leaders are identified and utilized in determining priorities and working out ways and means to meet the needs, including finding local resources such as the building to house the health post, equipment and manpower.

d) Local initiative and local resources are developed and utilized to solve the problem.

e) As the process continues, the Community becomes increasingly self-reliant and gradually gets involved in planning, implementing and evaluating the health services.

Thus, in this modelof structural participation, the villages as a unit or a community, is transformed from being a group of passive recipients of curative services and few patchy preventive services, to an active community taking responsibility for primary health care who would intelligently demand and utilize the inputs of the health services.

Fundamental to any model of community participation for health programmes, is health education and awareness. The degree to which the community is organized and mobilized for health care by the change agents, will determine the degree of community participation.

CHAPTER - III

STUDY OBJECTIVES AND METHODOLOGY

This chapter summarizes the critical questions which the professionals and administrators are likely to ask regarding effectiveness of the community participation. In the light of these questions, this chapter states the objectives and the methodology used in the assessment of the projects with regard to successful or unsuccessful community participation process and the results achieved for health and development of the community.

A. Community Participation -- a Process or a Product?

Keeping in view the health care needs of the country, particularly in the villages and urban slums, and the importance of community participation as a strategy, the Indian Society of Health Administrators (ISHA) devoted an issue of its Journal (July 1985) "Health Administrator" to the theme "Community Participation in Health Care in India". This Issue summarised the policy and programme experiences in the field of community participation in health care. It was felt that there was inadequate information regarding the process of community participation and programme factors leading to the success and failure of the projects. In order to learn these factors, ICMR was approached for a small grant to study the innovative projects. Keeping in view the rapid urbanization and the importance of primary health care in the urban areas, the Urban Health Projects through the Municipal Corporations of Hyderabad and Visakhapatnam were subsequently studied.

1. ISHA undertook this study of health and development projects, successful and unsuccessful, in widely different contexts--urban, rural and tribal. The study was designed to provide an understanding of the nature and dynamics of community participation in rural and urban India.It was hoped that this understanding would enable the planners and administrators in seeking community participation for effective health care.

2. To assess the nature and dynamics of community participation, in view of the socioeconomic scenario in urban and rural India, we were particularly concerned with the following questions:

a) Is Community Participation a process or a strategy?

b) What are the parameters of a successful and not successful community participation project?

c) What should be the nature of a project or an institution in which community participation will be effective? What should be the size of the project? What are the social,economic,financial and political constraints affecting community participation?

d) For effective community participation, the programmes should be conceived and executed by the community with whatever technical and financial support

which may come from the Government or other agencies. If so, is community participation an organizational or political process for decision-making?

e) Is community participation in primary health care illusory in a social set up in which the masses of the poor are excluded from effective decision-making?

f) How can there be community participation in a society, particularly in rural areas and urban slums where there are problems of unemployment, low wages, bonded labour, exploitation by money-lenders and control of the market by a few?

g) If community participation is a process of social change, is it possible to create social change without political change and raising the educational level of masses?

h) How can we make the community from that of a passive recipient to that of an active initiator?

i) Is community participation a process of motivating and mobilizing the people to act together and resist the domination of the traditionally powerful?

j) How do we help the community set up the goals and objectives of the developmental needs of the community? How do we motivate the members of the community?

k) How to identify and develop the leadership for community participation?

l) How do we resolve the conflicts among various groups for effective community participation?

B. Objectives of the Study:

Keeping in view the above perspectives in view, the specific objectives of the study were:

a. To study the innovative alternative approaches to health care projects in the public, private and voluntary sectors oriented to health and development of the country.

b. To study the processes and levels of community participation, as per the models of community participation, outlined in Chapter-II.

c. To study the factors associated with the change agent, the community, and the nature of programme goals which result in success or failure of the community participation as a strategy.

d. To assess the impact of the projects on health and development of the community.

e. To study the constraints in community participation in villages and urban slums.

f. To recommend measures for improved policy formulation programme implementation for effective use of community participation in health and community development project.

C. Methodology

From the literature and discussion with national leaders, twenty-seven projects were identified. However, when visits were made to the projects, some of the projects had been discontinued or closed.

We carried out indepth studies of about nineteen projects in varied backgrounds -- urban,rural,tribal,the organized sector government projects, national level projects,etc., to ensure that a wide variety of situations with different strengths and weaknesses were included.

3. The following parameters of each community health and/or development project were studied.

i) Demographic, health and geographic variables of the community and area served, prevailing at the start of the project.

ii) The philosophy and objectives of the change agents

iii) Nature of project, scope of activities and strategies envisaged by project leaders for achievement of the objectives.

iv) The process of project implementation/evolution of the project

v) Activities being carried out

vi) Organizational structure and leadership

vii) Process of community participation

viii)Collaboration and conflicts with the Government, other voluntary agencies, and the community.

ix) Results: in terms of impact on general health indicators, morbidity patterns, health services delivery data and, where relevant, impact on overall socioeconomic development of the community.

x) Financial Resources (and spending, wherever possible)

xi) Factors affecting the success of the project (or where relevant, the failure to achieve community participation

xii) Learnings from the Project

4. The following projects were extensively studied through visits to the project area, meeting with the project leaders, observation and interview of the community served, study of data furnished, and evaluation reports.

A. Rural Health and Socioeconomic Development Projects

1. Rangabelia-Project - Comprehensive Health and Rural Development Project, West Bengal

2. Comprehensive Rural Health Project - Jamkhed,Maharashtra

3. Child-In-Need Institute -- Maternal and Child Health and Community Development Project, West Bengal

4. RUHSA - Integrated Health and Community Development Project, Tamil Nadu

5. Rural Health Research Project - Mandwa, Maharashtra

6. A V R Educational/Foundation of Ayurveda - Comprehensive Rural Health Project, Tamil Nadu

7. Department of Health, Central Tibetan Secretariat - Primary Health Care Programme for Tibetan Refugee Settlements, Himachal Pradesh

B. Tribal Health Projects

8. Vivekananda Girijana Kalyana Kendra(VGKK) - Community Development and Health Project, B R Hills,Karnataka

9 Action for Welfare and Awakening in Rural Environment (AWARE), Andhra Pradesh

C. Health Cooperatives

10 Mallur Health Project - Cooperative Health Centre, Karnataka

11 Mini Health Centre Project - Voluntary Health Services - A Cooperative Health Services Scheme, Tamil Nadu

D. Hospital-Based Outreach Projects

12 K E M Hospital Project -Vadu Rural Health Project, Maharashtra

13. The Bandra Holy Family Hospital Society - Community Health Programme, Maharashtra

14. Nutrition Rehabilitation Centre - Madurai, Tamil Nadu

15. Padhar Hospital Project - Community Health Project,Madhya Pradesh

E. Health Care for the Organized Sector

16. The United Planter's Association of Southern India (UPASI) - Comprehensive Labour Welfare Scheme

F. Health Projects at National Level

17. Sulabh International - An Environmental Sanitation Mission, New Delhi

G. Urban Community Health and Development Projects by Governmental Agencies

18. Hyderabad Slum Improvement Project - Municipal Corporation of Hyderabad, Andhra Pradesh

19. Visakhapatnam Slum Improvement Project - Municipal Corporation of Visakhapatnam.

A detailed questionnaire was designed to be used by the investigators as part of the personal interviews and discussions. Published data and reports were obtained,wherever available ,to supplement the interviews. Field visits were made and interviews with beneficiaries conducted to assess the impact of the projects.

Each case study gives its own account of the local constraints experienced and strengths of the local community utilized for health and development of the community.

CHAPTER -IV

NATURE AND PROCESS OF COMMUNITY PARTICIPATION IN THE PROJECTS STUDIED

This chapter outlines the nature and process of community participation in a wide variety of projects-- the nature of community,goals,the change agent,the process of intervention, approaches to community organization and mobilization and the favourable or unfavourable results achieved

I. THE COMMUNITIES SERVED

The process of community participation has been studied in a wide variety of contexts. Certain general observations relevant to most of the projects are as follows:

a) The rural health and development projects have been started mostly in very poor socioeconomic conditions.

b) The experience of the leaders in trying to start the activities with community participation indicate that there was very little real sense of "community" in a village or town. Divisions along caste or economic class lines were powerful impediments. In addition, the tradition of family-based living with minimal or no community structures for civic activities was the rule.

c) In few exceptional cases, some form of pre-existing community organization existed prior to the beginning of the project as follows.

i) In the Mallur Health Cooperative, a functioning Milk Cooperative which handled most of the economy of the village under a village leader, and around which good proportion of the villagers' life was organized, already existed.

ii) In the case of the B R Hills Tribal Health Project,Mysore, community life with strong sense of community identity was a tradition among this tribal community. Traditionally, the families of a village shared all benefits of economic activity as well as the trials that tribals in recent decades have been faced with.

iii) In the case of plantation colonies ,served by the United Planters Association of South India Project, the sense of community came from being fellow-labourers, living in isolated small colonies on the plantations,with approximately similar incomes, industrial benefits and a common employer - employee relationship binding them with the employer.

Apart from these situations where favourable conditions for participation/organization for health already existed, in the case of the remaining"communities", the project leadership was committed first to community organization with second priority for the system of health care. Alternatively, the leaders adopted a strategy for entering the village, elicited a consensus on need for health activities through health education, and then implemented a community-based health system through village level health workers, rather than work for community organization first.

II. NATURE AND PROCESS OF COMMUNITY PARTICIPATION

Against this background,the features of community participation that emerged in these project areas are as follows:

1. Based on the nature of activities,the projects studied could be classified into two categories:

i) Health Projects

ii) Health and Community Development Projects

The extent of participation varied with the type of project. The variables affecting the process of community participation were:

a. Leadership Commitment

2. Projects where community organization and development were the major focus,rather than pure health care or socioeconomic inputs, showed the maximum involvement of the community. It is in these projects that the highest level of community participation (spelt out in Chapter II) namely, active community participation in planning, implementation and control of the programme, has emerged over the years. More particularly, high degree of participation has emerged in those projects where the leadership was committed to involve the community at all stages and ensuring the representation of the total community, *however slow, the process might be, and however delayed the desired health and development results might be*. These features are evident in the Rangabelia Project, Jamkhed, RUHSA, the Vivekananda Girijana Kalyana Kendra at B R Hills, the AWARE project in tribal areas of Andhra Pradesh , the Visakhapatnam Slum Improvement Project of the Municipal Corporation of Visakhapatnam and AVR Foundation of Ayurveda Project.

The leaders were more concerned with catalysing the process of community participation, right from the stage of making the people come out with their felt needs to the stage of enabling them to be a part of the planning, implementation and control of the health services in the area. In the cases of Rangabelia, Jamkhed and to some extent at AWARE, this involvement has gone to the extent of *planning by the community for health on a family basis*. In these projects, self-reliance of the community is maximally evident, and primary health care has been totally taken over by the community with some logistic and referral support of a base hospital.

3. At these very projects the entry point into the community by the change agent could have been either health, or socioeconomic development.(health was the entry point in the cases of Jamkhed, RUHSA, Vivekananda Girijana Kalyana Kendra and A V R Foundation. In the case of Rangabelia and AWARE, community development was the entry point). Whatever the entry point,the leadership, being committed to the felt needs of the community, took up work on the other component (health or socioeconomic development), recognizing the other as being a necessary and complementary component of the felt needs and overall development of the community.

Interestingly, the self-reliance for health at all these projects has been brought up parallel with, self-reliance in other fields of development in the village scene, like agricultural development and supplementary income-generation activities.

B. Institutional Based Intervention

4. There are the projects which have been started with an institutional base, with health as the chief objective, and where the projects have been chiefly health service-oriented (the Vadu Project - KEM Hospital, Bandra Holy Family Hospital Project, Nutrition Rehabilitation Centre Project,Padhar Hospital Outreach Prioject, Child-in-Need Institute (CINI) rural project,and the MINI health centres attached to VHS hospital) At these projects, while a relatively large number of staff and inputs of the agency is evident (in proportion to the population served), and greater degree of inputs is evident, the self-reliance of the community as a whole, for health, is not of a high order. Thus in these Projects which have been strongly institution-based, and the programmes built around the institutional objectives, the participation of the community has been limited. On the other hand, the projects which grew out of the felt needs of the community, such as Rangabelia, B R Hills, Jamkhed, AWARE and RUHSA, the involvement of the community has been much greater, so much so that the leaders envisage that even if they withdraw or terminate the activities in the Project area, the people will not only run their own primary health care system at the village level but also find some way of satisfying the needs for referral as well as supportive guidance to the primary health care workers.

C. Second-Line Leadership

5. At the projects, where a substantial degreee of self-reliance in the community could be evolved over the years, a strong commitment and focus of activities on developing second-line *leadership* at the village level for either health activities alone or both health and development activities is evident. These second-line leaders, developed in the villages have been, from the beginning, charged with the responsibilities of planning and implementing primary health care at the village level. The second-line village level leaders have taken over the responsibilities of organizing the community -based primary health care action, such as, maintenance of sources of safe drinking water, environmental sanitation, safe disposal of excreta and ensuring full community participation in the MCH and family planning programmes in addition to the responsibility for socioeconomic development. Therefore, the institution or the project staff are no longer continuously burdened with the task of sustaining community participation. The local leaders take up the task. On the other hand at most of the institution-affiliated projects, the community-based health workers have been motivated and charged with responsibilities of a task-oriented, a pre-conceived schedule of health activities. In the former category, the health problems of the community as demonstrated to the community-based workers, has been the take-off point to establish priorities and design task-schedules for health care and in these case studies, it is evident that involving the health care workers from this stage onwards, has resulted in greater involvement and self reliance.

D. Development of Community-based Health Workers and Referral System

6. The process of community participation as it emerged at each of the projects has been described in the respective case studies. *One feature common to all these projects has been, the development of a village level cadre of community based health workers, either entirely voluntary or paid a small honorarium. The need for this level of health workers living in the community and largely accountable to the community was felt in all the Projects. With basic training to these workers in health concepts, health education, maternal and child health*

care, registration of antenatal cases and eligible children for immunization, motivation for family planning and treatment of minor ailments, these link workers have been developed. Also ,all these projects have provided some form of referral services at a central institution, which could be small and manned by one or two doctors, or a full scale medical college hospital.

E. Role of the Village Health Worker (VHW)

7. At all these projects, the village worker (VHWs) system has taken root very well and yieleded very good results. Even in the case of certain projects where basic training was given to the health workers, motivational inputs by project leaders were provided, and some contact with the community leaders was established. This resulted in major changes in the health status of the people , especially in terms of reduction of preventable mortality. This feature is particularly evident in the FRCH-Mandwa project. The PHC doctor and ANMs,who were considered to be the middle level leaders,were frequently changing (since they belonged to the government sector) and could not provide continuity of leadership for the health care system. Yet the trained and motivated Village Health Workers, with some guidance and motivation provided by Project staff, could ensure achievement of the health goals in the community. Substantial reduction in infant and maternal mortality was achieved and family planning acceptance reached record levels.

F. Role of Cooperatives

8. The case studies of health cooperatives provide insights of the range of community participation that can emerge in the rural Indian setting. Two case studies of health cooperatives have been presented, namely, the Mallur Health Project and the Mini Health Centre Project of the Voluntary Health Services. Both these projects have been organised in the rural areas; they have evolved differently, and offer critical learnings for the success of health and family welfare programmes through community participation. Community financing of health services, and, inducing a process of orientation of the medically oriented doctors towards primary health care, was stressed by the Cooperatives.

In the case of the Mallur Health Project, initiated by the St John's Medical College, the health cooperative was started in a village which was largely organized around a successful milk cooperative. The development of the cooperative spirit for health and community involvement for health care activities was largely catalysed by the leaders of the milk cooperative. Thus establishing linkages with the economically active milk cooperative together with mobilization of the village leadership resulted in overcoming the caste and class prejudices and barriers. Major changes in health, sanitation, water supply, and family welfare occurred among all sections of the society including the poorest. All this could be catalysed without any financial inputs from any outside agency. The local leadership of the milk cooperative and youth leaders,who were developed later on, were also successful in orienting the doctor of the cooperative health centre to primary health care activities and induce him to provide guidance for community based primary health care activities. In fact, even though the original catalytic agency, the St Johns Medical College which initiated the Project, remained largely peripheral, the community through the milk cooperative ,gradually took over the entire planning, management ,and control of the health cooperative. Thus what began as merely community financing of the health service for the three villages through the milk cooperative funds,

evolved into high degree of community financing of the health service for the three villages. It was observed that some limitations and lack of systematization of primary health care was not due to inadequate community participation but due to high turnover of the doctors in charge of the cooperative health centre , who could not provide continuity of health leadership.

On the other hand, the community cooperative funding scheme started by the Voluntary Health Serfvice(VHS),in few rural areas near Madras,evolved very differently. No doubt, the strong leadership of the VHS succeeded in sustaining the community share of financing of the health cooperative by the rural poor over the years But the efforts involved were tremendous. Moreover, the experience of trying to replicate this pattern of financing in other areas has not been encouraging.

These experiences would suggest that mobilizing the community to finance health services in the current rural situation ,is a formidable task. In these, case studies of cooperatives we have a success story of the Mallur Health Cooperative, where the community went ahead from the stage of merely financing the cooperative to the stage of organizing community action for health care for sanitation, water supply, family welfare and nutritional practices which have undergone a drastic change and further the cooperative spirit spread to the area of education to overcome alcoholism in the villges and so on On the other hand, the Mini Health Centres scheme succeeded in achieving the HFA goals and in maintaining the partial community financing of the health services, but only through substantial institutional inputs and continuous efforts of the staff to sustain the community participation.

These experiences suggest that while health is not a priority for the rural poor, community financing can possibly be mobilized through linking health to the economically active cooperatives in the rural sector Given the present massive resource crunch for public funds and the growing health needs of a fast growing population, the government may find itself compelled to think of some way to mobilize the participation of the community in terms of financing the health services. In this context, the established rural cooperatives (agricultural, dairy and others) covering over 95% of the villages and over 50% of the rural population ,can become a potential force with which the health sector can be leaned up for securing community financing and participation for health and familywelfare.

The Working Group of the Planning Commission on India's Population Policies and Perspectives has emphasized the important role which the economically active cooperatives can play in the promotion of family welfare. The experience of the Mallur Health Cooperative suggests that given proper leadership and guidance by the medical and paramedical professionals and administrators, the rural cooperatives can assist far beyond famlily welfare to mobilize the community for health.

G. Role of Organized Labour

9. Among these case studies, is another case study of critical national interest, and that deals with the dyanamics of community participation by the labour force in the organized sector in the health and family welfare programmes. The United Planters Association of Southern India, an association of plantation owners, organized health services rather than medical services, and mobilized the labour

community on each of the plantations with population ranging from 100 to 5000. The UPASI had to contend with two apparently insurmountable motivations which militated against community participation--on the one hand were the profit oriented plantation managements who were extremely reluctant to invest in health. They wanted to restrict the services for the labourers to the statutory medical services required to be provided under the law. On the other hand, were the militant unionised plantation labourers who tended to look for a motive in every action initiated by the managements. This was exactly the response when incentive based family planning scheme was launched in response to the Government's call for a thrust to the FP programme in the organized sector. The laboourers resented it, feeling that the managements were implementing FP to save the cost on maternity benefits, since plntations are female labour- intensive and the savings to the management on maternity benefits can be tremendous.

The UPASI was able to provide the leadership to convince both the labourers and the managements of the mutual benefits to both of them, if the health status of the labourers could be improved. The strategy and process resulted in a dynamic participation, both by managements and the labour community in a Comprehensive Labour Welfare Scheme as a result of which the health status and family planning acceptance levels which the country is aiming at for 2000 AD. was achieved as early as 1989,within a span of few years. The process involved investment of resources by the managements and the labour for health through the link workers, by the labour community.

The Planning Commission, in its status paper on India's Population Policies and Perspectives,has stressed that the organized sector,which includes over twentyfive million workers and employees or almost ten to twelve crore population, is an accessible population to accept small family norm in the national interest. There already exists a Tripartite National Committee of Family Welfare (consisting of Governments, Employers and Trade Unions). This Committee needs to be strengthened and provided clear directions and leadership to proceed for a participative concrete plan of action to achieve health and family welfare. The experience of UPASI has shown that it is possible not only to achieve the small family norm but also to achieve participation of the labour force towards markedly improved health as well as labour productivity, which can contribute tremendously to the development of the country.

H. Community Participation in the Urban Community

The case studies of the Visakhapatnam Slum Improvement Project and the Hyderabad Slum Improvement Project provide examples of community participation exercised by Government Organizations, namely the Municipal Corporations of the two cities. In the Visakhapatnam Slum Improvement Project, the major strategies used for enlisting community participation and success of the health and developmental programmes in the slums were:

a. Community Organization into Neighbourhood Committees which were involved at every statge of the programme from planning to implementing health, housing, income generation, vocational training, etc.

b. Training and Human Resource Development of Community Based Volunteers: These people included the Neighbourhood Committee members, mother leaders, and community health volunteers.

c. Linkages of health and FW programmes with housing, socioeconomic and civic amenities improvement programmes and intersectoral collaboration for better participation.

d. Involvement of the voluntary agencies: The success of community participation enlisted for Hyderabad Slum Improvement ,over two decades for various socioeconomic programmes, has been based largely on the strategy of community organizations into slum associations which were involved at every stage of the slum development programme.

Indepth case studies of these two projects have been made particularly with a view to identify the leadership, administrative, and strategic factors which resulted in the success in enlisting community participation by the government organizations.

10 Rather than the initial economic status prevailing in the community, development of human resources of the community and community organization have been the chief factors in greater development of self-reliance and participation in health. Rangabelia, Jamkhed, VGKK, AWARE and Visakhapatnam Slum Improvement Projects exemplify these facts where, extremely poor socioeconomic conditions, did not prevent the project leaders bringing forth community participation of a very high degree. On the other hand, even in relatively affluent conditions like the Mallur Health project low degree of commitment and efforts by the agency and lack of continued leadership by the health leader resulted in lesser utilization of the community effort.

Irrespect of the demographic factors: economic status, rural,urban,organized ,unorganized,homogenous or hetrogenmous, community participation can be a successful strategy towards human resources and community development. The intervening variables or the process factors are the determining variables of the degree of effectiveness or ineffectiveness of the community participation strategy.

CHAPTER - V

FACTORS INFLUENCING THE SUCCESS OR FAILURE OF COMMUNITY PARTICIPATION

This chapter examines some of the programme factors which resulted in effective Vs ineffective community participation based on the projects we have studied.

A. LEADERSHIP FACTORS

The critical factor that has characterized the successful projects,has been leadership. This leadership factor could be characterized as follows:

1. Commitment to Health and Community Development:

In almost all these projects, strong commitment of one or two persons to health care and/or community development has been able to change the populations of large number of villages from subservient, poor, apathetic, dependent, fragmented groups, to transformed communities. The range being, --from health conscious communities availing health care from their voluntary village health worker, to self-reliant communities planning and implementing their own primary health care system.

2. Cognitive Flexibility and Perceptual Ability

Next to the commitment of the leadership, a critical factor has been the willingness and ability of the leaders/health agency to go beyond health to meet developmental needs of the community and a willingness to accept that health is just one of the felt needs and not a priority need. As a natural consequence, in these projects, the community's participation in the agencies' programmes including health programmes, has been greater. This is evident in the projects of the AWARE, Andhra Pradesh; Vivekananda Girijana Kalyana Kendra, B R Hills, Mysore; Jamkhed, Maharashtra; Rangabelia, West Bengal; RUHSA project in North Arcot district of Tamil Nadu;Municipal Corporation of Visakahapatnam, where the community participation in health and results of community participation are closest to the ideal envisaged in the Alma Ata Declaration. *Thus, a multisectoral approach has been far more successful with quick results for health and community development.*

3. Development of second line leadership in the community to take over responsibility .Leadership commitment has been exemplified in develop ing the second line leadership. In such cases the population covered by the project could be expanded extensively, and rapidly. The AWARE Project, B R Hills, Rangabelia, Jamkhed ,and the Visakhapatnam Slum Improvement Project, are examples.

Where the leadership of the project was committed more to a service programme, *in terms of providing services and inputs, and achievement* of preconceived health care targets, rather than to development of the people in the community to take up the responsibility of health care, the participation has been limited largely to availing services. This is evident in the hospital out-reach

projects, the FRCH - Mandwa Project near Bombay and the Tibetan Health Services based at Dharamsala, Himachal Pradesh.

In the CINI project in West Bengal, with the evolving nature of the programme from a service programme orientation to a community development orientation, the nature of community participation has also been evolving to more and more participative nature.

4. Community-based Leadership rather than Institution-based Leadership

Wherever the services to the project areas were given as outreach services, from an institutional base, with a preplanned package of services, in spite of training Village Health Workers and widespread health education, community participation has been limited. In these projects, it could at best be termed as community acceptance and cooperation for the health and family welfare services. Few additional features might be seen like the cooperative funding in the Mini Health Centre Project, some donation of building in villages for Village Outreach Project, depending upon the initial designing of the project by the project leaders. But in terms of participation by the community and self-reliance in health care, it has been limited.

Conversely, *the highly successful projects are those where most of the Project activities are centered around the community and its needs, rather than the institutional goals and objectives.*

In the projects where the project leaders settled down in the service area and identified with the people, even though they may have started work with provision of some basic curative services, *community involvement in health evolved over a period of time.* It appears that people need to identify with the individuals and agency first, before a consensus emerges on the commonality of goals of the agency and the community, and brings forth participation.

For example, in the FRCH Mandwa Project, in spite of developing a full fledged first level referral hospital located in the Project area manned by qualified staff, the leaders who resided in Bombay about 100 Km from the project area, could not bring forth the participation of the community to the desirable extent over a period of 15 years. On the other hand, Jamkhed,B R Hills,AVR Foundation projects were able to create a change in a short period.

5. Continuity of Leadership

A notable feature of the Municipal Corporation staff of Hyderabad and Visakhapatnam, is, the maintenance of a stable cadre of UCD Project head, community organizers and social workers who have been working with the slum community and identified with the slum community for two or more decades. These staff were not transferred except when they themselves asked for it. An outstanding reason for the success of the slum improvement projects of these two cities has been, the committed and continued association of these persons with the slums. This finding has enormous relevance in the health system of our country, wherein there is high turnover of doctors and other paramedical personnel in the rural areas, and where we expect the Primary Health Centre to achieve community participation. These projects have shown that it is not the PHC that can elicit community participation, but the continuity of leadership, who identify with the community and its needs, that can achieve community participa-

tion. *In all the projects studied, community participation has not been organized around institutions, but around people settled in the area as the nucleus and catalysts of change.*

B. COLLABORATION WITH THE GOVERNMENT AND OTHER VOLUNTARYAGENCIES

6. Next to the leadership factors affecting the success of a project, has been the strategy of collaboration with several Government and other agencies. In all the outstandingly successful projects (B R Hills, Rangabelia, AWARE, CINI, Jamkhed,RUHSA and Visakhapatnam Slum Improvement Project of the Municipal Corporation) there has been extensive collaboration with governmental agencies of multiple sectors - health, agriculture, veterinary department, industries department,social welfare department,etc. The voluntary agency/project leader has acted as a catalyst to promote utilization of the funds allocated under the various heads for the area. The focus has been on channelizing funds to deserving beneficiaries, (mostly) ensuring repayment of Government loans in the spirit of self-reliance and ensuring proper utilization for the specific purpose.

In all the above mentioned projects,*the allocated governmental budgets and bank loans were effectively utilized*; the recovery of the loans by the government/banks to be recycled to other beneficiaries was very high, and *results in terms of health and developmental impact, exceptional.*

7. *In all the outstandingly successful projects, the funds for development* (mostly obtained through collaboration with the governmental and banking agencies) *were not given as a charity or unconditional input.* The philosophy of all these projects has been, that development cannot come out of injection of large amount of funds, but by development of human resources to utilize inputs, create assets and return the input to be recycled to other beneficiaries in the community. This is exemplified extensively in the AWARE project wherein about 80% of all loans disbursed so far (both Governmental or foreign funds) have been recovered and recycled in the project area.

In the field of health, collaboration for purposes of providing immunization services, vaccines, and family welfare services from governmental sector has resulted in higher immunization and family welfare coverage.

C. SOUND REFERRAL BACKUP SERVICES

8. Projects with sound referral backup services have been able to build up community faith in the agency, acceptance and participation in health care. For this, it is not necessary that the first level referral services should be highly sophisticated with specialists and super-specialists. Provision of medical, surgical and obstetric services to deal with the most common emergencies, with a bare minimum of physical facilities even in improvised rural buildings, was enough to gain the confidence of the people. With the exception of RUHSA project sponsored by Christian Medical College - Vellore and the Mallur Health Cooperative co-sponsored by the St.John's Medical College, most of the successful projects built up their first level referral health centre after starting the project, mostly with local resources or labour.

D. CAPITAL INVESTMENT NOT NECESSARY FOR COMMUNITY PARTICIPATION AND DEVELOPMENT

9. Capital investment in the area with large number of staff and development funds, has not proved to be a crucial factor, as amply proved by the Vivekananda Girijana Kalyana Kendra Project at B R Hills, Rangabelia Project, Jamkhed, Child-In-Need- Institute Project Operating in very poor communities with little or no external charitable agency funds, they have been able, by sheer human and managerial inputs, to bring forth economic and health development.

E. ABILITY TO RECOGNIZE AND UTILIZE THE STRENGTHS OF THE LOCAL COMMUNITY

10 An important feature of the successful projects has been the ability of the leadership of the external agency to capitalize and build on the strengths of the local community, and harness it to overcome other hurdles, chiefly the hurdles of caste and class divisions, and extreme poverty.

In the case of the Mallur Health Cooperative, the St John's Medical College Leadership successfully harnessed the local leadership of the Milk Cooperative to develop the health cooperative. In the case of B R Hills, where the tribals had virtually no assets even in terms of marginal land, their strong tradition of community life and sharing was utilized to build up health and development. In the case of Rangabelia Project, the widespread popularity of communist ideology among people was utilized to bring the people together for action to transform them from passive recipients waiting for development aid from government to self reliant communities planning for their own health and development.

In the case of the UPASI - Comprehensive Labour Welfare Scheme Project, the project leaders utilized the urge in the plantation managements to increase the labour productivity to motivate them to implement a health scheme; the leaders also utilized the advantage of relatively small, closed, remote, homogeneous plantation labour communities, to bring them together for health activities.

F. COMMUNITY BASED CADRE OF HEALTH WORKERS

11. The highly successful and not-so-successful projects (in terms of enlisting community participation) have one common characteristic. That is, with development of a bonafide community-based cadre of health workers given proper training, on-going guidance and supervision, motivation from the health centre leadership, and some logistic support, it is possible to bring up the health of a community to a reasonable level, going well and beyond the HFA targets laid down for Health For All by 2000 AD. Even in very poor socioeconomic circumstances, without much improvement in per capita income as indicated by economic surveys conducted (at RUHSA Project, Rangabelia, B R Hills and others), there has been improved quality of life, almost nil maternal mortality, infant mortality brought down as low as 35-60/1000 live births,better nutritional

status, high family planning acceptance and high immunization and MCH coverages.

In fact in the FRCH - Mandwa Project, and the Bandra Holy Family Hospital Society Project, fairly average staff, motivated by an institution-based leadership could achieve the targets laid down for HFA by 2000 AD, within a period of 5-6 years.

These Projects illustrate that to achieve a fair degree of community participation and to achieve the goals of HFA by 2000, training and development of adequate number of Community based Health Workers is essential.

G. INTEGRATION OF TRADITIONAL HEALTH SYSTEMS AND PRACTICES WITH MODERN SYSTEMS AND TECHNOLOGIES

12. In almost all the projects, the indigenious skills (whether midwifery or traditional medicines) which did not clash with modern preventive practices like aseptic delivery procedures, immunization and ORT, were added to traditional midwifery and child care skills, rather than compelling local dais and local practitioners to abandon effective age-old remedies and skills. The latter attitude strategy would be expected to result in hostility towards change rather than a change in health practices.

The result of this approach is particularly evident in projects like the B R Hills Project, the AVR Education Foundation and the AWARE Project. For example, in the B R Hills project , encouragement of traditional midwifery skills with the added training component of antenatal care, immunization and aseptic delivery procedures, virtually all deliveries in the population of about 20,000 have been conducted without a single case of Caesarean section or maternal death in the last ten years.

Similarly in the AVR Foundation Project, the Village Health Workers and practitioners of traditional medicine, combined with use of modern antenatal and child care, were able to add to a rich body of knowledge to existing knowledge regarding maternal and child care, cure of certain chronic diseases, etc. and at the same time, bring down maternal and child mortality in the area.

In summary, the factors influencing the success or failures of the community participation and community development are: Committed and dedicated leadership, collaboration with the governmental and non-governmental agencies, capital investment to improve the infrastructure, utilizing the strengths of the local community, training and development of a community based cadre of health workers, and integration of traditional systems of medicine and practices with modern systems and technologies. These development are the strategies recommended in the National Health Policy, Seventh Five Year Plan and re-emphasized in the Eighth Five Year Plan.

CHAPTER - VI

RESULTS OF COMMUNITY PARTICIPATION IN HEALTH AND DEVELOPMENT

This chapter reviews the results in terms of health improvement and community development achieved as a result of the community participation.

1. CHANGE IN HEALTH STATUS

In all the projects where an evaluation was carried out, it was found that with the participation of the community, even if only to the extent of availing services from a trained voluntary village community health worker (backed by a referral service), has resulted in marked improvement of health status.

a) Changes in Health Indicators

The changes in the general indicators in areas with relatively restricted form of community participation has been almost comparable with changes observed in comprehensive health and development projects. In project areas of the Bandra Holy Family Hospital Project, the FRCH - Mandwa Project, the birth rates have been brought down to about 20/1000 population from high pre-project levels. In the case of intensive community development and health projects like Rangabelia and RUHSA Projects too, the reduction in birth rates and increase in family planning acceptance has been accompanied by other far reaching changes in these cases.

Infant mortality has come down remarkably in almost all project areas from a level of 120-130/1000 live births to about 50-70/1000. Maternal mortality and undernutrition, toddler mortality and undernutrition have been brought down remarkably. In many project areas, especially where comprehensive development was undertaken, eg. Rangabelia, incidence of diarrhoeal diseases, typhoid and paratyphoid, and cholera was brought down to very low levels in a short period of 3-5 years of commencement of the project.

Other indicators like crude death rate have also been brought down to the level of about 9/1000 laid down for the HFA Goals for the year 2000 AD within a period of five to ten years.

b. Changes in Health Service Indicators:

Coverage for almost all the public health programmes has gone up considerably. In many of the projects like B R Hills Project, AVR Foundation Project, the Mallur Health Cooperative and others, family planning acceptance improvement was not a major component of the programmes. In fact, Family Planning services were not provided by the base hospitals or health centres at these projects. Yet, with implementation of the health and development programmes, contraception prevalence has gone up several fold. In the case of Mallur, it has reached the levels laid down for the HFA goals for 2000. Antenatal and immunization coverage, ORS utilization in the community have gone up to unexpected levels being in the range of 90-100% in the more intensive health projects and about 60-70% in the predominantly developmental projects.

2. SOCIAL CHANGE

In the projects where comprehensive health and development work was undertaken, there is a marked social change visible. In projects like AWARE, B R Hills (VGKK), RUHSA, and Rangabelia, community organization, awareness, self-reliance and independent action for development and health is of a very high order. At the CINI project on the other hand, where the project has operated chiefly as a service programme and only lately oriented to community organization, inspite of being development-oriented from the inception, that degree of self-reliance and community initiative is not evident.

In all project areas, however, community health practices have changed remarkably, even in certain hard-core areas traditionally difficult to crack . This is particularly seen in cases of use of ORT in diarrhoeas sufficiently intensive to lower child mortality due to diarrhoea, preventive hygienec and protected water supply practices, achieving healthy nutritional status in spite of poor socioeconomic conditions, etc.

3. ECONOMIC DEVELOPMENT

In the case of the development projects, the extent of rural development has been exceptional, given the background of poor natural resources, high population densities and adverse conditions, against which development has taken place. Though an evaluation of incomes in monetary terms may not indicate change, the people felt that there was a quantum jump in quality of life, better resource and quality of life as observed in the RUHSA, Rangabelia, VGKK - BR Hills project and others.

These results suggest that the key to social and economic development, including health development, is community participation and human resources development of the community. Leaders at national, state, district, block and village levels need to be trained in working with the community, seeking collaboration and creating a process of social change. Long term development of the community, improvement of health status, and achievement of HFA goals would be realized through community participation.

Chapter-VII

SUMMARY AND RECOMMENDATIONS

A. SUMMARY

1. Community participation has been recognised, as an essential element of community development, including health development. The practical experiences of countries like China, Cuba and Indonesia demonstrate the potentials and competence of the local people for managing most of the local health problems. The impressive achievements in the field of health made by China in the area of control of communicable diseases, in decentralization of health units, in the use of paramedics and village people who had no formal medical education and in mobilizing over 900 million people to engage in health activities are important learnings that people can participate in health programmes and contribute in other ways for better planning, better implementation and improved health care.

2. In India importance of community participation has been emphazised in the last 50 years, in the various Committee Reports, Five Year Plans and National Health Policy Documents.

3. This study was undertaken to assess the nature and process of community participation in various projects initiated in the government and voluntary sector. Effective community participation was defined as per the WHO definition as the process whereby the community develops resources and competencies for effective planning and control with very little reliance on an outside change agent, on a long term basis.

4. A list of twenty-five projects in the country was prepared. However, some of these projects, when visited, had been discontinued. Case studies on the following 19 projects are presented:

A. Rural Health and Socioeconomic Development Projects

1. Rangabelia-Project - Comprehensive Health and Rural Development Project West Bengal

2. Comprehensive Rural Health Project - Jamkhed,Maharashtra

3. Child-In-Need Institute -- Maternal and Child Health and Community Development Project, West Bengal

4. RUHSA - Integrated Health and Community Development Project, Tamil Nadu

5. Rural Health Research Project - Mandwa, Maharashtra

6. A V R Educational/Foundation of Ayurveda - Comprehensive Rural Health Project, Tamil Nadu

7. Department of Health, Central Tibetan Secretariat - Primary Health Care Programme for Tibetan Refugee Settlements, Himachal Pradesh

B. Tribal Health Projects

8. Vivekananda Girijana Kalyana Kendra(VGKK) - Community Development and Health Project, B R Hills,Karnataka

9. Action for Welfare and Awakening in Rural Environment (AWARE), Andhra Pradesh

C. Health Cooperatives

10. Mallur Health Project - Cooperative Health Centre, Karnataka

11. Mini Health Centre Project - Voluntary Health Services - A Cooperative Health Services Scheme, Tamil Nadu

D. Hospital-Based Outreach Projects

12 K E M Hospital Project -Vadu Rural Health Project, Maharashtra

13. The Bandra Holy Family Hospital Society - Community Health Programme, Maharashtra

14. Nutrition Rehabilitation Centre - Madurai, Tamil Nadu

15. Padhar Hospital Project - Community Health Project,Madhya Pradesh

E. Health Care for the Organized Sector

16. The United Planter's Association of Southern India (UPASI) - Comprehensive Labour Welfare Scheme

F. Health Projects at National Level

17. Sulabh International - An Environmental Sanitation Mission, New Delhi

G. Urban Community Health and Development Projects by Governmental Agencies

18. Hyderabad Slum Improvement Project - Municipal Corporation of Hyderabad, Andhra Pradesh

19. Visakhapatnam Slum Improvement Project - Municipal Corporation of Visakhapatnam, Andhra Pradesh.

A questionnaire was devised and after being duly approved by it ICMR was used as a guide in eliciting information, Leaders and staff of the projects were interviewed as well as members of the community. Published and unpublished reports were used as reference material.

B. Results

5. The results of the successful community participation projects show improvement in general health indicators as per the National Health Policy targets - birth rates brought down, higher acceptance of family planning, infant mortality, and maternal mortality brought down considerably, infectious diseases considerably reduced, incidence of diarrhoeal diseases, typhoid and cholera brought

down to low levels. The results also show that the projects have contributed to socio-economic development and overall development of the community and democratic way of life.

6. The factors contributing to effective and ineffective community participation are:

a) Leadership - Committed and dedicated for service and health development; long term commitment and sacrifice for change in the community

b) Development of a second line leadership in the community

c) Training and development of a cadre of health workers within and from the community.

d) Identification of the leadership with the community and being a part of the community.

e) Collaboration and integration with the governmental agencies and programmes

f) In the case of health, a sound referral system which resulted in building confidence in the community

g) Development of infrastructure for community development by mobilizing resources from within and without

h) Planning and developing the projects around the strengths of the community

i) Integration of traditional values, ethos, systems and practices with modern approaches and technologies

C. RECOMMENDATIONS

1. Keeping in view the objectives of the National Health Policy and the emphazis laid on community participation in the Seventh and Eighth Five Year Plans as well the results of this Study, it is suggested that national and state level seminars on "Community Participation" be initiated, to create awareness, understand the obstacles and constraints , and facilitate the process.

2 . T he periphery level leaders at district, block and local levels be trained in the process of community participation and collaboration.

3. Highly motivated and committed workers be elected and placed at various levels (from national to periphery) to make community participation a success.

4. The officers should be placed in positions for atleast five years, given realistic targets and adequate resources should be provided. This Management by Objectives Approach will help build involvement and commitment.

5. The voluntary agencies should be more actively involved in health programmes, in training as well as initiating projects; in collaborating projects with the Government sector.

6. Innovative systems and rewards be initiated for effective community health development programmes through community participation at local, block, district, and state levels.

7. This publication could be printed by the Government of India for wider circulation for education and development of the community, professionals and administrators. ISHA would be happy to discuss the collaborative printing and circulation programme.

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Case Study : I

RANGABELIA - COMPREHENSIVE RURAL DEVELOPMENT AND HEALTH PROJECT

Rangabelia village is a small village in Rangabelia Island, of Sunderbans area, district 24-Parganas in West Bengal. A comprehensive rural and health development project,which was to influence the lives of villagers in more than fortyfive surrounding villages, had its beginnings in Rangabelia village. Shri. Tushar Kanji Lal a school head master, who was posted to Rangabelia High School in 1967, started informal developmental work with the villagers along his wife Smt.Bina Kanjilal. Later,in 1975 he founded the Tagore Society for Rural Development after resigning from his post to work wholly with the people for all round development. The following case study illustrates the transformation in health and development that could be achieved, through a systematic process of total community involvement, right from scratch, without any funds and without preplanned project approach. There was only the determination and commitment of the leaders, Tushar Kanjilal and his wife, to move the people for socioeconomic development.

THE COMMUNITY SERVED

The project is located in the Sunderban region, which forms a part of the delta belt between the Hooghly and the Padma-Meghna Estuaries. The Health Project serves a population of about 80,000 in the forty five villages of Rangabelia Island. The profile of the population and the area served is as follows:

a. The area is predominantly rural

b. More than 90% of the total population is engaged in agriculture and allied activities.

c. A single crop is grown in the year predominantly. Only a small portion that is about 5% of land could be so far utilized for producing the second crop (during Rabi season by irrigation). Rest of the land is uncropped during the dry season.

d. The only crop produced is traditional Amanpaddy during kharif seasons, the yield being not more than 18 mounds peracre, which falls short of the most minimum requirements of the existing, population for a bare existence. About 90% of population belong to the landless, marginal and small farmer categories. With the single cropping pattern, the average employment of the population is for about 70 - 100 days in the year at a daily wage rate of about Rs.15/- per day. This brings the per capita income the agriculture to not more than Rs.1500 per year.

e. Demographic Profile: Population growth rate in the region is very high, it was 34% in 1951-61, 41% in 1961-71 and 40% in 1971-81. Proportion of Scheduled Caste/Scheduled tribes to total population in approximately 56%. Percentage of literacy in the area is 22%.

f. Most of the families were indebted to private money lenders who accounted for 70% of the total credit disbursement in the village. Public sector institutions

such as like banks,cooperatives etc.,provided only 20% of the credit availed in the area.

g. Transport and communication is not satisfactory. There is frequent flooding during heavy rains and high salinity of of soil due to ingress of saline water during tidal waves. Poor drainage facilities, inequitable distribution of land and irrigational resources owned by Government (these facilities being concentrated in the hands of a few rich farmers), all these factors together account for a high degree of poverty and backwardness in the area.

h .Health status of the community Before the health project was begun, a baseline survey was conducted in 1976, in a population of about 9,000. The survey showed that all the health indicators were at a dismal level. The crude death rate per 1000 population in 1976 was about 19 per thousand of which enteric fever accounted for 25%. The maternal mortality rate was 14 per 1000 population, infant mortality rate was very high - for instance, neonatal mortality rate itself was 96.5 per 1,000 live births, perinatal mortality was 136 per thousand. There was a high rate of abortions.

The population served under the health project consists of about 80,000 persons in the forty five villages on Rangabelia Island and surrounding areas, about 70 KM away from Calcutta.

THE PROJECT ; PHILOSOPHY, BEGINNING AND OBJECTIVES

The Project began as an effort in comprehensive rural development keeping in view the felt needs of the people which centered around poverty and hunger. The Project is based on the communist ideology of equitable distribution of wealth and resources, which Mr Tushar Kanjilal, a school teacher of Rangabelia High School keenly pursued, after seeing child after child hungry in school.

The Project has been concentrating on arousing people from their apathy towards socioeconomic backwardness, poor health conditions and poor quality of life. At the same time, the project staff seek to provide logistic support to organize the community to ensure their participation and enable them to become self-reliant for their own health and development. The leadership believes that merely channelising some funds from external or foreign agencies to build up some capital assets for the community, is not development. Development can only be achieved if people come out with their problems and search for solutions themselves, plan and implement the solutions themselves.

The project leaders began with informal meetings with the villagers to establish their needs. This resulted in a community decision to carry out a socioeconomic survey to understand the economic, social and cultural problems. This resulted in formulation of objectives of the socioeconomic development programme as follows:

(i) To evolve the health care programme with an emphasis on the prevention of diseases and health education in conformity with the special characteristics of the region with minimum dependence on qualified doctors,institutions like a health centre or hospital, drug-based medical care - all of which entail prohibitive expenditure.

(ii) The health care programme must be the ultimate responsibility of the community, the curative aspect should ultimately be the responsibility of the State, and health conscious ness and healthy living should be the responsibility of the people so that the burden on the curative aspect would be minimized.

(iii) Maximum importance to be given to a decentralized village based effort involving villagers to solve some basic health problems.

(iv) The health project should work in close collaboration with the comprehensive development project. One must support and complement the other.

(v) Replicability of health project in a similar setting of poverty and backwardness should be considered in designing the project.

The specific goals and targets to be achieved within five years time, were set up as follows:

(a) Improvement of housing conditions of atleast 20% of the families belonging to the project area and encouraging hygienic environment by improving the drainage system.

(b) Prevention of mal-nutritition in children under five years of age, mass immunization and family planning.

(c) Sanitary, latrine system with indigenous material at minimum cost to cover atleast 20 % of families in the project area.

(d) Improve the nutritional intake in very poor families by providing finance and other supportive assistance poultry, kitchen gardening and other nutrition-related family activities.

(e) Curative services for simple ailments and T.B Patients.

(f) Health education among the masses.

NATURE OF PROJECT AND SCOPE OF ACTIVITIES

The project aims at comprehensive socioeconomic and health development, chiefly through development of the local human resources and channelizing their activities in the right direction. The focus of project leaders is, to create awareness and organize the village community into a cohesive unit, to participate in the process of development on the one hand and provide supportive guidance, technical guidance ,and liaison with the Governmental agencies for the health, agricultural and development activities on the other.

The project covers forty five villages of Rangabelia. Intensive activities are being carried out in five villages with a population of 10,000. The activities are as follows:

Socio Economic Development

1. Organizing second crop during the rabi season, cultivation of high yielding variety of paddy, during the dry season; in support of these activities, providing agro-based service assistance to ensure steady supply of fertilizers, seeds and training inputs.

2. Development of pisiculture.

3. Organizing weaving of cotton goods and marketing of the goods.

4. Aiding animal husbandry.

5. Providing credit to self employed and seasonally employed people.

6 Creation of an Agro Service Centre Creation of irrigation facilities like consumer cooperative societies towards supportive services for agricultural activities and income Provision of seed fertilizers,pesticides and tractors for 12 % service charge to the poorer farmers construction of village godowns where farmers could store crops till the prices rose, so that profits increased.

7 Establishment of a women's training cum production centre and organizing village based economic programmes for the women

8 Soil conservation and social forestry providing assistance to the honey, fisherman and wood collectors cutters providing assistance to local artisans in their traditional occupations

9 500 non-formal education centres for the non-school going children and school dropouts in 80 villages in the surrounding area

10 80 Adult Education Centres are being run by the project one in each village.

Health Promotion Activities

1 . Medical Services:

(a) At the village level, simple illness is treated by trained village health workers, with the support and periodic guid ance of the medical officer.

(b) The Health Centre at Rangabelia has an outpatient clinic, laboratory, in-patient facilities, a small operating theatre and X-ray facilities. Cases referred by the village health workers are treated in the out patient clinic and if necessary admitted as in-patients. Family planning operations, minor operations, X-ray examination, are some of the facilities provided.

(c) Maternal and Child Health Services: - Prenatal, intra-natal and postnatal care, mass scale immunization

2. Community Health Services:

(a) Organizing and maintaining supply of safe drinking water including periodic chlorination of drinking water reserve ponds, maintenance of hygienic conditions of the surroundings of these ponds, etc.

(b) Installation of low-cost latrines and improvement of drainage system towards control of water-borne and sanitation related diseases.

(c) Nutrition Programes: Supply of nutritious food to children and expecting mothers; promotion of family and community kitchen gardens,and encouraging intake of balanced diet by the entire family ; supply of cow's milk to the newly born children who do not get breast feed; promotion of backyard poultry,goatery and duckery at the village level, towards improvement of nutritional status of the community.

(d) Intensive health education, promotion of personal hygiene and planned family.

3 .Training

(a) Village health workers are selected by the villagers and trained at the Health Centre at Rangabelia, to organize and maintain the community health services and medical services.

(b) Dais are trained in the conduct of safe delivery, both at the health centre and in the village setting.

(c) Suitable boys and girls of the area are sent to different institutions for training in pathology,radiology, etc.

Community Organization

a .Mahila Samitis have been organized in every village to understand the health problems of the family and to promote certain activities such as kitchen gardening, backyard poultry etc. which contribute to the nutrition of the family. The samithi ensures use of safe drinking water in every family, promotion of personal hygiene, planned family, improvement of housing conditions, nutrition of babies and children,pre and post natal care, etc.

b . Group Meetings: Groups of 15-20 families are organized in each village to identify problems at family level and organize future action for each family. Representatives of the groups meet fortnightly at the "Para" or village level, and para representatives attend, regularly, the Project meetings, monthly, at Rangabelia.

c. Health workers selected from villages are trained to organize the health activities in every village, and to guide the Mahila Samitis in matters relating to health.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP OF THE HEALTH PROJECT:

Leadership

The leadership and coordination for the Comprehensive Development and Health Project is provided by Shri Tushar Kanjilal who is the Honorary Project Director. Leadership for each development programme is provided at the Village level by workers who have been trained in the local agricultural practices,local

fishing practices and local skills of the artisans. The training is then complemented with expertise on modern methods obtained from technical experts of the respective Government Departments. The Project Director coordinates the health project activities with other branches of the development projects. He, along with and other village level workers, ensures the participation and involvement of the people in all the programmes undertaken by the Project including the health programmes.

Organizational Structure of the Health Project consists of the following:

1. The Honorary Director of the Health Project is a local medical practitioner and social worker of great repute, with 23 years experience in Sunderban.

2 Two Medical Officers. The medical officers are full-time and residential.

3 Five locally trained nurses are attached to the central medical team.

4 Eight local young men have been trained in pathology, radiology,pharmacy and accountancy

5 Fortyfive trained Village Health Workers work in different villages.

6 Seventyfive trained dais

There is no single outsider in the whole set up. The medical officers are paid a consolidated monthly remuneration of Rs 3000/- Allowances of other staff are decided by their representatives at the Village Meeting Para and Grama Sabha, taking in to consideration their necessities commitment, services and motivation. These allowances paid to the workers has bearing with the service charges paid by the village to the Health Project under different heads. The maximum salary paid to an individual worker is Rs 400/- per month and the lowest amount is Rs.175/- per month.

The leadership of Shri Kanjilal and his own example of simple living has resulted in the Project being able to attract motivated workers in spite of relatively low salaries. His commitment to community involvement and participation at every step of development of the project, has resulted in this philosophy percolating among the staff, voluntary workers of the community, village level leaders, and finally the families.

PROCESS OF COMMUNITY PARTICIPATION

A.Participation at the Grama Sabha level:

The community has been involved in the developmental and health activities from the stage of defining health and socioeconomic needs, formulating the programme, implementing the programme, and evaluating the programme. Each village has a *para* or Grama Sabha in which the villagers participate. For effective functioning the village is subdivided into small groups of 15-20 families which meet every week, and discuss the development plan for each and every family of the group. At the beginning of every year, a comprehensive health and socioeconomic development plan for every family is drawn up. Health planning for the family is a vital component of the total plan. These families are neighbours,

living close to one another and know the conditions of each other very well.They meet at the hut of one of the families by rotation. They are guided by the trained village workers and the Mahila Samiti members on health issues, and the whole group discusses the health care necessities of each family,as well as and the duty of the family for individual and community health. For instance, if a child has been born in one of the families or if there is a pregnant mother, in one of the families, the issue of immunization and nutrition supplementation through family/community resources is discussed and the decision based on the merits of the situation. Again, if there is a need for the family to go in for contraception or sterilization, owing to sufficient family size or large family size, the group will discuss and recommend the same. At the meetings when the total plan is drawn up, every adult man and woman with family has to be present, so that there is a total family consensus on the matter. The decisions on health matters are linked to community assistance for economic activities, since the merits and eligibility of each family situation for loans, subsidies and other assistance, is also decided by the same Group. Similarly, the ability of the family to install a sanitary latrine during the year is assessed and the family is persuaded - guided to install the same by suitably making provision for the total plan of the family for the year. Each group submits the individual family plan to the Para. The consolidated plans from Paras which cover all aspects including social problems, economic problems, health problems and actions for the same, are submitted and the actions to be taken for implementation are decided.

The fortnightly *Para* meetings are held at a village hut which has been built by the villagers themselves for this purpose.It is ensured that the decisions of the Group are implemented at family level by persuasion, education, and if both these fail, by excluding that family from community development activities,in case the family does comply.Nothing is given as totally free to the beneficiary; the Group ensures the repayment of loans through social pressure in the case of defaulters; on the other hand, guidance is made available to the families to utilize the loans productively. The villages in the Project area are motivated to consume the produce of the Project area - for instance handloom products woven by families in the project area have to be pur chased by the people in the Project area. Social pressure is applied for people to maintain quality of product, and to ensure as far as possible, marketing within the area itself.

The *Paras* identify suitable local village youth to be given training for health activities, to man the Water Resource Development Programme, Pisciculture Development Programme, Nutrition and Sanitation Programme,Women's Welfare Programme and Agricultural Extension Service Programme. Competency and dedication are the deciding factors for selection. These boys are given training at the government institutions. Thus the people from the community formulate the programmes,provide manpower for almost all the development and health programmes. This results in several advantages, namely, a good rapport between the development workers and villagers which facilitates success; the man since he belongs to the village remains dedicated and sticks to the post. Many such workers are honorary - they work at their own family occupation and in addition, do the development work.

B.Participation in activities for Community Health

The community in these villages has fenced the ponds earmarked for safe drinking water, takes part in periodic disinfection of the drinking water by addition of bleaching powder, and periodic excavation and re-excavation of ponds to

maintain them as sources of safe drinking water. In the area of sanitation, the community has constructed improvised latrines and implemented environmental sanitation principles in such a manner that, in these villages, perfectly clean surroundings are maintained. Immunization cover age, improved nutrition, have all been made possible by the Group,para and Project level meetings and participation.

C.Participation through Financial Contributions

The community participates by contributing financially to the Project. For instance, in the Health Project Rs 10,17,023/- was spent from 1978 to 1982. Out of this, Rs 4,81,618/- (almost 50%) was borne by the villagers who paid the service charges under various heads. actually, the participation of the villagers in terms of the voluntary labour in construction and excavation activities, and labour donated at reduced wages, comes up to a substantial amount. In fact, it turns out that people are paying about 80% of the recurring expenditure of the project.

COLLABORATION AND CONFLICTS

A Collaboration with the Governmental Agencies

The leadership of the Project believes that collaboration with the Government in developmental activities is essential to utilize the developmental budget allocated for the area. The leadership feels that one of the crucial roles of voluntary agencies is identification of deserving beneficiaries, facilitating the loans and subsidies to the illiterate, needy persons, who cannot deal directly with government machinery, and, ensuring that other types of Governmental assistance including subsidies are *really utilized for developmental purpose by the community and families involved, and not for unproductive purposes, which frequently is the fate of welfare and development funds allocated under Government Programmes*. Thus a substantive activity has been to ensure that most of the Government allocation for the welfare and development programmes, are productively utilized.

B. Conflicts with the Governmental agencies were essentially of the nature of delays due to apathy, lack of interest and concern for the development of the poor,corrupt practices, etc. Thus,there it was no conflict of goals but problems with motivation and efficiency of government functionaries arose from time to time.

C. Conflict Experiences within the Community

Conflict experiences stemmed from the basic strategy and content of the project -- namely community awareness,participation and organization for equitable distribution of allocated resources--for example, scarce irrigational resources. Understandably, the first source of conflict within the community arose from the middle and rich peasantry, who had previously controlled almost all the irrigational potential for raising the second crop, the financial credit, resources, etc. They tried to prevent the village representatives from reaching the State Planning Board of the West Bengal Government, so as ensure to formulation of and implement programmes for equitable distribution of resources.

Again after, the village paras drew up a detailed plan and estimate for various developmental activities, such as harnessing irrigational resources, and submitted them to the State Planning Board for budgetary allocations,the privileged groups in the community tried to corner the funds and influence governmental machinery to benefit themselves, by attempting to form village committees of their own class.

This was the chief source of conflict, and was overcome by community organization and intervention of the Tagore Rural Development Society at the State level.

RESULTS

There has been extensive socioeconomic and health development in this population of about 10,000/- distributed over five villages in Rangabellia island since 1969, when Shri Tushar Kanji Lal, the newly appointed Head Master of the Rangabelia High School started the work . This is evident by the drastic change in the health and socioeconomic indicators. In this poor community, with minimal external assistance, chiefly through a strategy of organization and development of its human resources, together with some provision of curative health service, the changes are as follows:

A .Mortality & Morbidity Statistics

In the Project area, the death rate per 1000 population has come down from 19 in 1976 to around 7.5 in 1989. The death rate from enteric diseases (water, sanitation and personal hygiene related diseases) has come down from five per 1000 population to 0.6 per 1000 population in 1982. Death from the three childhood scourges - tetanus, diphtheria and measles come down from about five per 1000 population to 0.5 per 1000 population in 1982.

The disease rate of water and sanitation related diseases per 100 persons during the year went down from 65 in 1976 to 12 in 1989. This has been a steady decline over the years, commensurate with the proportion of population having access to safe drinking water, which has gradually increased from 45% in 1979 to 90% in 1982 and almost 99% in 1989. Almost all of these women under antenatal care completed their immunization schedule during their pregnancy, and almost all eligible women among them were covered by the nutritional programmes. Cases of tetanus and diphtheria in children between one month and three years came down drastically. From an incidence of 38 cases of tetanus, and 22 cases of diphtheria in 1976, it came down to four cases of tetanus and three cases of diphtheria even in the expanded population of 1989. The incidence of pertussis came down from 23 cases in 1976 to only one case in 1989. The perinatal mortality rate came down from 136 per 1000 births (including still births), to 23 per 1000 births, in 1982 and 19/1000 births in 1989. The infant mortality rate in the Project area was 39 per 1000 live births in 1982, when the IMR, for India as a whole was 125 per thousand live births. Maternal mortality rate has come down from 4.3 per thousand pregnancies in 1976 to .5 per thousand pregnancies.

B. Specific Achievements of the Health Programmes

(i) 25 ponds have been declared as reserve tanks for drinking water in villages of the Project area. Regular chlorination of these ponds as well as fencing for

protection of surroundings from sullage is the responsibility of the village grama sabha which utilizes the youth organizations for this work

(ii) 282 improvised latrines have been constructed in accordance with the decision of the village meetings.

(iii)1025 families have so far been sanctioned loans by the village meeting for the improvement of their houses and remoulding of their houses.

(iv)10525 people have been given medical aid at the village level by the health workers.

Similar achievements have been documented in nutrition, antenatal, child health and other activities of the health programme.

FINANCIAL RESOURCES AND EXPENDITURE

The financial resources utilized for the developmental programmes are chiefly in the form of developmental allocations under the various ministries of the Government of West Bengal and Government of India, and, loans given by the Banks.

Financing of the Health Project is as follows:

A total amount of Rs.10,17,023/- has been spent in the health Project from 1978 to 1982. This includes all construction expenses and cost of excavation and re-excavation of ponds. An amount of Rs.4,82,618/- has been realized from the service charges paid by the villagers under different heads. The net deficit comes to about Rs.5,35,405/- which mainly due to the capital expenditure for construction and excavation. On intimate scrutiny, it comes out that actually the people are paying 80% of the recurring expenditure incurred by the health project. The capital expenditure for construction and excavation was made up by assistance from "Bread of the World", West Germany; Bhoruka Charitable Trust, and the Government of West Bengal. It is ex pected that with the complete establishment of basic capital - intensive assets required for the Project, (which is almost complete), the Project has every potential of becoming self sufficient in future.

FACTORS IN THE SUCCESS OF THE PROJECT

A .Leadership Factors

1. The motivated leadership and commitment of Shri Tushar Kanji Lal to attack the problems of poverty and ill health in spite of limited natural resources was chiefly responsible for successful community participation for health and development.

2 A commitment to the strategy of human resources development to utilize available resources for better quality of life and health, rather than a reliance on external sources of funding for economic inputs to the community. The latter strategy tends to make a community passive and dependent rather than becoming self-reliant and take responsibility in the process of development

B. Strategy Factors

1. The strategy of building up most of the organizational structure for development (the Agriculture wing, Duckery, Health wing,Sanitary wing, Fisheries, etc.) from within the community. This resulted in the trained personnel sticking to their posts since they belonged to the same village and also enabled them to work as volunteers in addition to their routine occupations. Their sense of identification with the villagers, and feelings of recognition by their fellow villagers motivated them to work with commitment.

2. The financial viability of the Project and achievement of spectacular results in the field of health, without much improvement in the percapita income, without intensive investment in the health programme, was also partly due to the above mentioned strategy.

3. A health care programme with real stress on prevention and its functioning as an integral part of the total development programme.

4. Finally, the effective and meaningful involvement of the common man in the affairs of the health project right from the process of survey, identification of priorities, decision making and implementation, has resulted in a commitment to achieve the objectives which have been set by the people themselves.

LEARNINGS FROM THE PROJECT:

i) The villages all over India are basically the same in that, a majority of the people are very poor and uncared for. The general living conditions of those in Bengal and Bihar appear to be worse. The villagers have to be motivated and educated to be united and when once they are united, they are capable of achieving great things.

ii) Traditional development work undertaken by Government or banks or institutions donating grants, etc. will not go far, and on the other hand makes the villagers lethargic and become a slave to receiving monetary assistance year after year. Real development and progress of the villages will be achieved only when the villager pays for it and involves himself completely from conception to completion. A little push or pull may be necessary from outside agencies now and then to keep them on the right track.

iii)Experts are really not necessary for running development programmes. Village youth, selected by villagers themselves based on their attitude and interest, if given proper training, will do better than the experts in the long run. This was proved at Rangabelia. In fact, specialists from Indian Council of Agricultural Research, PUSA, and other government organizations come to Rangabelia to consult the person incharge of the agricultural programmes, who is a local volunteer trained for the purpose of improving upon local methods and successful introduction of newer crops and rotation of crops.

iv) Rural development is meaningful only if it is comprehensive.

v) Unless the workers are dedicated and disciplined and work in a spirit of sacrifice,uplift of the poor is not possible, because there is lot of difference between talking about the poor and working among and living with the poor.

Case Study : II

COMPREHENSIVE RURAL HEALTH PROJECT -- JAMKHED

The Comprehensive Rural Health Project in Jamkhed Taluka of Ahmednagar district was started by a young doctor couple Dr R S Arole and his wife in 1971. Initially, it was based at a small rented room of Jamkhed town providing some curative services and later grew to a comprehensive rural health project with its own health centre, first level referral hospital, trained field staff and voluntary workers in every one of the 175 villages covered by the Project. The following gives an account of how the leadership of the Project with a strategy of community involvement and human resource development was able to mobilize the community for health and related developmental activities, and transform the health scenario of this apparently ill-fated area,prone to long years of drought and drinking water scarcity, to low agricultural productivity and high mortality, morbidity, and birth rates.

THE COMMUNITY SERVED

1. General

The rural community served consists of a population of approximately two lakhs in 175 villages of Ahmednagar district and adjoining parts of Beed district in Maharashtra State. The villages are compact in size and population varies from 500 to 3500; majority have a population of 1500-2000; 88% of the population work on the land. Most of the land owned by a few families while 60% of the farmers are either marginal or landless farmers. The area is drought prone and soil is very poor and rocky with low agricultural productivity (mostly fit only for coarse millets like jowar and bajra); the socio-economic difference between the rich landlords and poorer peasants is not marked. During drought years, food and water scarcity hits all people. Drinking water was a continuous problem in the area not to speak of water for washing and other purposes. The socioeconomic status of women was very low and they worked harder than the men, doing most of the manual labour in agriculture while the men worked only on those agricultural operations where labour was provided by machines or animals. A rigid caste structure tended to divide the community along seemingly irreconcilable lines.

2. Health Status

The health status of the population was poor . Maximum morbidity was among under-fives, particularly due to diarrhoea and malnutrition. Infant mortality was about 110/1000 live births, maternal morbidity and mortality was high due to almost nil antenatal, intranatal and postnatal care; family planning acceptance in the area was of the order of 5-10% among eligible couples.

At the starting of the Project, the nearest facility for medical emergencies was the District hospital located 82 kms away from the town of Jamkhed.

THE PROJECT: PHILOSOPHY BEGINNING AND OBJECTIVES

The Project was commenced in 1971 by Drs Arole and Mrs Arole who aimed to provide health care services with an emphasis on family planning, with full community participation, in the least developed areas of the country. Initially, with their public health as well as clinical experiences, and keeping in view the felt need of the community, curative services was the entry point. Based on the advice of the Village Council of Jamkhed and following the donation of an old veterinary clinic building for the clinic by the Council, the medical clinic was started at Jamkhed town, situated at the cross roads for districts, which was thus well connected to develop a Base Hospital. In response to the felt need of the people, a good medical, surgical, and obstetric centre to handle emergencies was gradually developed; simultaneously, contacts with the neighbouring villages was established and field work was done to study the needs and priorities. Keeping in view participation the need for and benefits to the poorest sections and the harijans, as well as the need for overall rural development, the Project activities were diversified from mere emphasis on health services, to an emphasis on catalyzing the process of equitable development of the community.

The broad objectives of the Project are to provide comprehensive health care to the people including the poorest, with full participation of the community, and to develop the local community for overall socio-economic and agricultural development, which alone can really make a lasting impact on their health status.

NATURE OF THE PROJECT AND ACTIVITIES

The Project is a comprehensive, rural health Project providing a base for curative, preventive and promotive health services, with a strong community-based cadre of village health workers at the base, and the Jamkhed hospital at the top providing referral services and leadership to the Project area. As a part of health promotion, facilitation and leadership for agricultural and allied developmental activities are also provided. Health services are directly provided to a population of 2,00,000 in Ahmednagar and Beed District. Training in enlisting community participation is being imparted to health service personnel of the entire Ahmednagar district .

A. Health Activities

1. A full fledged 40-bedded hospital provides medical, surgical and obstetric specialist facilities to deal with emergencies, sterilizations, cataract surgery, etc. In addition, the Centre serves as a documentation and research centre of the community's vital events and health profile; coordination of activities of VHWs of the villages; supplies ; initial and ongoing inservice training to 175 VHWs and ANMs; monitoring of activities and health programmes including national programmes, and evaluation.

2. A Team consisting of the doctor, paramedical worker and social worker visits each village, on fortnightly basis to attend cases referred by VHWs, diagnose and initiate leprosy and tuberculosis treatment, immunization, MCH Services, and other preventive services. In addition, they utilize this opportunity to assist,

coordinate or resolve problems in community organizations, socioeconomic developmental activities, etc.

3. At the village level, the VHW undertakes health education, identifying and motivating underfives and mothers for MCH services; motivation for family planning and distribution of conventional contraceptives; screening of cases to detect possible leprosy and tuberculosis and referral; ensuring their regular treatment; maintenance of health records of all families in the village , etc. She is assisted by the Mahila Mandals and the Youth Farmers' Clubs who independently run the supplementary nutrition programme for under-five children and pregnant mothers.

4. In addition, the Centre has undertaken the responsibility of training Village Health Guides for entire Ahmednagar district in community organization, and training to other health personnel to organize the community in their own districts and training for the District Training Teams of Maharashtra State in community organization for health and family welfare. These training programmes are carried out at the hospital and peripheral centres, at the request of the Government of Maharashtra.

B. Community Organization

The progressive youths of the villages are organised into Youth Farmers Clubs who inturn initiate similar Clubs in neighbouring villages. The clubs organize the Mahila Mandals. The youth undergo training in better agriculture, veterinary and cottage industry practices, for popularizing these activities in the village. They undertake and liaise with the Project Directors for agricultural developmental activities; locally take charge of food-for-work programmes; income generating activities, including cottage industries; small businesses for the landless farmers and women; assist the VHW substantially in the health activities; and run the supplementary nutrition programme. These clubs also undertake health surveys, community sanitation work like soak-pits for drainage, safe drinking water supply, etc.

Community volunteers drafted by these clubs assist the Government health staff to identify women to be trained as Village Health Guides (VHGs) in other villages of Ahmednagar district.

Village veterinary workers have been trained and are functioning to give treatment, vaccinations and guidance for poultry farming and upkeep of dairy animals.

C. Socioeconomic Programmes

The Project organises and catalyses improved agricultural practices such as construction of check-bunds to store rainwater and check soil erosion; provision of quality seed and fertilizers ; large scale afforestation; development of plant nurseries; food-for-work programmes and activities such as desilting of tanks, deepening of wells, village tanks , soak pits, etc. These are organized with the Youth Farmer's Club as the key implementors. The Project Directors and staff provide logistic inputs,and if necessary, funds from donor agencies, liaison with the Government, and provide training to the local people to gradually become self reliant in these activities. A key input is, training to the farmers in both technical and social skills for all these activities.

Improvement of women's status through group meetings, and income generating schemes for them are also undertaken with the help of loans from banks, Government and other agencies.

The Mahila Mandals conduct nonformal education classes for adults and school drop-outs, sewing classes for women and youth, and sisal fibre processing classes. Libraries run by them number about 96; kitchen gardens, nurseries for plant saplings, bakery, and other businesses are also encouraged and supported by the Mandals, which thus promote income-generating activities of women and consequent increase in social status of women.

PROCESS OF PROJECT IMPLEMENTATION

The process has all along been tuned to the community, chiefly through organizing and ensuring broad representation of all the socio-economic groups and caste groups in decision making.

Before the start of the Project, the Village Advisory Council of Jamkhed was consulted, who welcomed the Project Directors to start curative services in a donated building. Later on, space for inpatients was also donated, and subsequently, accommodation for a staff of 15-20 people was also constructed. Following the establishment of curative services at Jamkhed, villagers attending from nearby villages for various illnesses or obstetric problems would be educated on the need for their active participation to prevent such illnesses. Soon the village outreach attempts were started. At first, an informal advisory committee with leaders of eight villages (including harijans, politicians of all parties), was formed and educated to create health awareness and to bring out their needs. This resulted in the community articulating their need for food, water employment and socio- economic development rather than health services. In response, the idea of Youth Farmers Clubs was mooted keeping in view the fact that, development of agriculture and agriculture- related employment was crucial for development in any other aspect of life. The Youth Farmer Clubs were formed, by the Project leaders after identifying progressive youth from the villages, from all sections of the community, in consultation with the community leaders.

With their involvement, and the help of some voluntary agencies specialized in tubewell digging, the priority need for drinking water was solved. The first wells were located in the harijan settlements, so that, while they were ensured access to water, during water scarcity, the upper castes would also use the facility.

Next, with the assistance of overseas agencies and donors within the country, food-for-work programmes were launched to improve the utilization of water resources and other related activities to improve local agricultural productivity, as well as to employ the landless. The activities undertaken were, water conservation(through check-dams), improved farming methods, afforestation, etc. At the same time the Project leaders, with the help of the Youth Farmer's Clubs, constantly educated the community on the need for safe drinking water, sanitation and improvement of maternal and underfive's nutrition and health. Keeping in view the drought of 1972-73 and food scarcity, community kitchens were started with a cooperative approach. The community contributions ranged

from food grain contribution at harvest time, to setting apart, reclaimed agricultural land (fallow land converted to cultiviable land) for growing grains exclusively for the community kitchens. From this kitchen, underfives and pregnant mothers are fed round the year. Implementation of this programme, including running the kitchens, getting the fire wood and the food grains, was organised by the Youth Farmers' Clubs of each village.

In addition to working in their own village, these Young Farmers were induced to go to neighbouring villages to spread the message and encourage the local villagers to start similar activities there. Thus the process has been one of catalyzing the process of self-reliance for health and development in a few villages, and thereafter providing guidance and support for the snowballing effect into other villages. Thus the Project area of eight villages in 1971 could expand to about 175 villages in 1987.

For better health services, at the request of a few Farmer's Clubs, trained ANMs were posted to the area, given a place to stay, and guaranteed safety and support by the Farmer's Clubs. However, the curative bias of the ANMs , the distance they maintained with the people, their unwillingness to share with the community their knowledge of preventive and promotive health, showed up within a year of operation. In spite of supportive second level services by the doctor (the Project Director), a paramedical worker and social worker through weekly visits, inspite of complete cooperation of the Farmer's Clubs to identify and enumerate all underfives, pregnant mothers and eligible couples for target activities such as antenatal care, family planning, immunization and health education, inspite of the training given to the ANMs at the Project on health education and family planning, it was found after one year that the villagers' expectations of preventive and promotive care,(created by the awareness-building strategy of the Project leaders), were not fulfilled. The Farmer's Clubs themselves came out that outsiders could not be change agents, and that a suitable woman in each village should be trained for the responsibility. Accordingly, a middle-aged woman who was motivated for community work, often illiterate but able to get along with others,with life experience of child bearing and rearing, and family planning was selected and trained from each village to be the Village Health Worker, with the responsibilities of maternal and child health care, family planning, motivation, sanitation, health education, and conduct of safe delivery. In all these matters, including record keeping of births and deaths and other vital events, growth monitoring of children, registration of antenatal cases and eligible couples, they were assisted by the Youth Farmers' Clubs.

Gradually the need for Women's Clubs (the Mahila Mandals) was felt so that the VHWs could maintain better communication with women and organize them to raise their social status, which was essential for the health of the women. The Youth Farmer's Clubs themselves organized these clubs, often beginning with own spouses as members, since women had a low status, were underconfident, and often, their participation in social activities was curtailed by their families.

With these strategies, it was found that, while the ANM in a period of one year remained an outsider giving only curative services, the VHW within six months was well-accepted and, in addition to cure of minor ailments, other services also took off very well such as, preventive services like immunization, family planning, growth monitoring, etc.

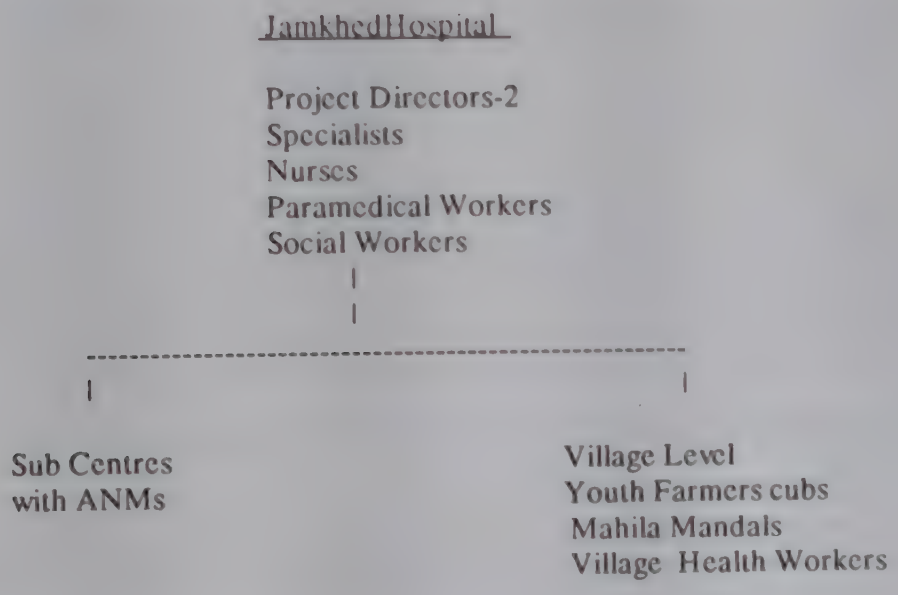
Gradually, other activities were taken up such as, identification of suspected cases of leprosy and tuberculosis, referral of cases to the fortnightly clinic conducted at each village by the Project team, and maintaining regularity of treatment of known cases of leprosy and tuberculosis. The VHWs were willing to share their knowledge with the Youth Farmer's Clubs, and, since they belonged to the same village, they worked in the evenings or in their free time for the health activities.

Further, with increasing involvement of the Women's Clubs and the Youth Farmer's Clubs, VHWs even undertook health and illness surveys relevant to the area, to identify the health needs of the community and to respond accordingly. As a result of these surveys, for example, soak pits were constructed for drainage of kitchen and bath water.

Once the process of participation is initiated in a village, the village is led towards self reliance and to spread this message and influence to neighbouring villages.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The leadership to the Project is provided by the Project Directors Drs Arole and Mrs Arole who began work as a two member team, to provide health services. Today, they inspire and provide leadership to several hundreds of second line leaders developed in the villages -the members of the Youth Farmers Clubs and the Mahila Mandals, the Village Health Workers, and the staff/of the Hospital. The Organizational structure is shown in the figure:



PROCESS OF COMMUNITY PARTICIPATION

A. Community Participation in Health Activities

1. The Jamkhed Project began as a curative clinic and subsequently developed into a hospital in a renovated building donated by the Village Council of Jamkhed

2. The informal advisory committee formed to take decisions on health action had representation from all sections of the society, besides the community leaders.

3. The decision to post ANMs to the village to provide first level care and preventive services was taken at the request of the Youth Farmer's Clubs who were convinced by the Project Directors of the preventable nature of most of the morbidity affecting their community.

4. The Youth Farmer's Clubs have been intensively involved in the control of TB and leprosy, particularly the latter which is endemic in the area: Through extensive educational activities such as songs, dance, and dramas, the youth have created such an awareness that, almost 100% of incidence cases of leprosy come under treatment very early, and treatment compliance is very high. Similar was the response to the problem of tuberculosis.

5. The Farmer's Clubs and women, organized themselves, and constructed numerous drainage soakpits to drain away waste water which has resulted in clean surroundings.

6. The Farmers Clubs and Mahila Mandals are closely associated with the Village Health Workers. They have taken over the responsibility for growth monitoring of underfives. They also organize meetings with the VHWs to educate themselves on child care practices, Oral rehydration therapy, contraceptive practices, and a wide range of health issues, so that they can influence the other villagers to adopt these healthy practices. This health education is incorporated with their routine work with the other villagers for socioeconomic development activities.

These Youth Farmer's Clubs were formed consisting of local young progressive farmers. These Clubs became the backbone of the Project in initiating and taking up responsibility of the agricultural and socioeconomic as well as health development. At their request, at first, ANMs were posted. Subsequently at their own request, the second tier of health workers were trained. The Youth Farmer's Clubs have undertaken the responsibility of making arrangements for accommodation for the ANMs, providing assistance to VHWs in their work, including maintenance of vital statistics, enumeration of underfives, mothers, other vulnerable groups, TB and leprosy case detection. The Youth Farmers Clubs have been running the community kitchens for supplementary nutrition to the underfives and pregnant mothers almost from the start of the Project.

B. Community Participation in Socioeconomic Development

1. The food grains for the community kitchen is procured by contribution of grains from the families and from the cooperative farms that have emerged from reclamation of fallow lands for agricultural purposes. The children participate by bringing sticks of wood for fuel for the community kitchens.

2. The Youth Farmers Clubs and Mahila Mandals are responsible for identification of beneficiaries for the food-for-work programme, loans for agricultural development and small business development, other loan and subsidy schemes, keeping in view, that the poorest need to be reached first . In particular the Mahila Mandals ensure that women of the poorest sections are benefited by schemes for women.

3. The community has donated land and buildings wherever it was within the capacity of the community to do so. When the buildings had to be constructed, such as, building for Jamkhed Hospital, the community provided voluntary labour. Materials and money was donated by the relatively more affluent farmers.

4. Thus, overall, the community has been involved in the Project right from the planning stage and delineation of needs, to implementing and even evaluating the programme. All programmes whether health or socioeconomic are evaluated for efficiency, and the villagers define the parameters of evaluation. Guided by the Project Directors, the villagers conduct the survey themselves, with some training to carry out the survey, and then come back to discuss any change that may be needed in the programme. The decision to train VHWs was taken based on an evaluation of the ANMs, work which showed up as inadequate to meet the need for preventive health services, particularly MCH and family planning.

5. The entire socioeconomic development infrastructure including the grassroot level health workers (the VHWs) of 150 villages, is composed of volunteers suitably trained, retrained and oriented at the Jamkhed HQ. Besides, these volunteers have been largely responsible for the spread effect from the initial eight villages to 175 villages, a process which has been carefully guided and steered by the Project Directors.

6. Volunteers of the Project area assist with the training responsibilities undertaken by the Project to train village health guides for the district. In addition to assistance with training, selection of suitable candidates to be in trained is done by these volunteers.

COLLABORATION AND CONFLICTS

A. Collaboration with the Government

Initially when the Jamkhed Project health services were started, the Government agencies ignored the Project. Subsequently, for some time, the Governmental agencies and the Project ran parallel services. Realizing the efforts of the Project in the National Programmes, especially family planning, the Governmental agencies (hospital and PHC of the area) are now working in a cooperative spirit with the Project.In addition to supply of vaccines and other inputs, there is now extensive collaboration between Government and the Project. Many of the developmental works are taken up with loans and budget allocations to the area from Banks, government agencies, etc.

The Project has been given the responsibility of training suitable persons as VHGs in the entire Ahmednagar district. In addition,government personnel ranging from medical officers, IAS probationers, and District Health Officers as well as other health staff, and staff of departments of agriculture, etc. are posted here for training and experience in community participation for Government programmes. The Jamkhed Project is now partly funded by the Government of Maharashtra and Government of India.

B. Collaboration and Conflicts with the Community

Initially, there was enthusiastic response from the community and a guided movement towards equitable participation of all sections of the society towards health and development. Yet, some degree of conflict inevitably arose due to rural castism,and the insistence of the Project Directors that the harijans and the poorest should be on the advisory committee and participate in decision making.

However, the commitment of the Project leaders to the principle of health through full community participation,and equitable distribution of the benefits, resulted in winning over dissenting factions.

C. Collaboration with other Voluntary Agencies

The Project leaders have continually sought the assistance of voluntary agencies. In the very second year of the Project, during the drought, assistance of cash and manpower was availed from voluntary agencies specialized in drinking water provision and techniques. Subsequently, when agricultural development and allied activities were undertaken, voluntary agencies (in addition to international agencies) assisted and guided the implementation of food-for-work and other programmes.

The Jamkhed Project has served as a training ground for innumerable health and development workers of voluntary agencies in the country and abroad.

RESULTS

The result has been one of remarkable improvement in health, family planning practice and development of this backward area, which, at first sight appeared doomed to backwardness, with its high population, low agricultural productivity and chronic drought prone conditions.

Briefly the results have been as follows:

A. Social Change

The community has been transformed with a change of attitudes, from a fatalistic attitude to poverty and want,to a self-reliant community pushing forward for better health and socioeconomic development through proper utilization of available resources. Women's status has improved a lot and they are openly acknowledged as important change agents in the community. Casteism and untouchability is almost invisible in these villages.

B. Health

There has been a marked improvement in health, nutritional status and family planning practice in the population. The birth rate has gone down remarkably, health knowledge improved, nutritional status of children has improved ; the prevalence of leprosy in the project area has come down due to high coverage for treatment and ensuring regular treatment; infant mortality has come down from about 110/1000 live births to about 55; case detection and regularity of treatment of TB cases is the best in Jamkhed taluka. Large number of handicapped persons have been rehabilitated with artificial limbs and leprosy patients

are accepted as normal persons in the community. The incidence of malaria has declined steeply.

C. Agriculture and Economic Development

Impressive gains have been made in agriculture - large areas of fallow land reclaimed for agriculture; intensive afforestation work has been done; multiple cropping, etc. have changed the socio-economic scene.

The firm commitment to community participation involving all sections, particularly the under-privileged and outcastes, has resulted in a large scale movement for social change in the area. The people in the Project area also serve as inspiration and catalysts for initiating change in other neighbouring villages and thus have a snowballing effect in neighbouring areas. A very small core staff, mostly technical (medical and paramedical) are paid staff. The rest are voluntary change agents from and within the village communities who account for bulk of the project activities.

The change process has been made possible by the open-ended planning of the Project Directors who started with provision of curative services but at the same time were committed to the principle of community participation.

FACTORS IN THE SUCCESS OF THE PROJECT

1. The overwhelming factor responsible for the success has been the dynamic and flexible leadership provided by the two Project Directors Drs. Arole and Mrs Arole. They have been able to rise to the felt needs of the community, constantly involving the community in solving its own problems, ready to provide assistance and support, and corrective guidance when the process went astray, e.g. when power groups tried to monopolize the benefits.

2. The strategy of eliciting community participation in health and family welfare by responding to felt needs articulated by the community, resulted in high degree of responsibility being undertaken by community leaders and youth.

3. The chief constraint felt by the Project leaders has been, firstly, the difficulty in finding motivated medical and paramedical professionals to work in rural areas, and secondly, the difficulty to influence them sufficiently to give up the curative bias and be one with the community as mutual learners and sharing for learning. This has often created constraints of staff availability for the many programmes and activities.

Case Study : III

CHILD-IN-NEED INSTITUTE, WEST BENGAL

The Child-In-Need Institute(CINI) runs a maternal and child health project in 24-Parganas district of West Bengal. This is an institution-based project built around the concept of child survival. In 1974, Dr.S.N.Chandhuri, a practising paediatrician of Calcutta, stirred by the hunger and deprivation of children, initiated the CINI project with headquarters at Daulatpur village in 24-Parganas District, and related meternel health services with a vision of developing comprehensive child health services, and relater maternal services to improve child survival. The following is an account of the evolution of the project as well as the progress in drawing the involvement of the community in the project.

THE COMMUNITY SERVED

The community initially consisted of a small ill-defined population spread over eight villages and three slum units of South 24 Parganas district,and has gradually expanded. Now CINI serves a population of over 86,000 living in 50 villages of Bishnupur Block I and II in the rural area of South 24 Parganas. The land is low lying with heavy rains inundating large areas of it, and, inadequate roads, rendering many areas inaccessible for prolonged periods. People are generally poor and most of the households (more than 75%) used to earn less than Rs.69 per capita per month (the cut off level for rural poverty). Almost 45% are rural landless labourers. It was estimated at the start of the project that nearly 70% of children suffered from various grades of malnutrition. The commonest causes of mortality among children were diarrhoeas, respiratory illness and measles. The communist ideology is strongly prevalent among the people.

Within this population served, the specific target population of CINI, consists of about 4000 pregnant and lactating mothers and about 12,000 children under the age of five.

THE PROJECT : PHILOSOPHY,BEGINNING AND OBJECTIVES

The project was started by a consulting paediatrician of Calcutta, Dr.S.N. Chaudhuri, who was frequently visiting few villages to understand the rural conditions. His interest in the health of rural children was kindled during his three years' Master's degree course while he did in Community Health and Management at Jamshedpur. During a School Health Survey, the experience of seeing most children in a rural school hungry, made him realize that curative services are meaningless in the contest of widespread malnutrition and poverty. He felt the need for a child health service, which seeks to provide curative treatment along with preventive needs, such as, low cost food and immunization. One of the major needs, he felt is, for paramedicals in rural areas to reduce dependency of the population on doctors. Based on these stirrings, the Loreto Child-In-Need services was started at Thakurpukar village near Calcutta, in 1974.

Subsequently, the scope and objectives have been expanded to include community development, without which, an isolated health programme cannot

make an impact on the quality of the child's life. Now, the objectives are as follows:

(1) To develop and implement a community based low cost primary health care programme of care of mothers and children, supported by referral services.

(2) To organise effective action-oriented women's groups (Mahila Mandals) which will initiate and manage programmes for Maternal and Child Health and Community Welfare.

(3) To raise income levels especially for women and to undertake community welfare activities i.e. improvement of school education, road construction, etc.

(4) To train health and development workers from both government and non-governmental sectors, and from selected groups from the community.

(5) To undertake basic research in primary health activities.

Thus the objectives of CINI, have evolved so that, they are chiefly development-oriented *including health of mothers and children as a component, rather than child health being the major objective.* The developmental activities are in keeping with the philosophy of the CINI which aims to make the people self-reliant for their own health.

NATURE OF THE PROJECT AND SCOPE OF ACTIVITIES

It is a comprehensive project, covering health, nutrition, education, maternal and child health, community organisation for health and development, and provision of organisational, logistic and training support to develop income-generating activities in the area.

A .Units of CINI and their Functions

The CINI headquarters is located at Daulatpur, and subunits are located at Samali, Moyna and Chetna; each unit specializes in different types of activities. They are coordinated by the CINI, Daulatpur.

CINI - Daulatpur : Administrative office, Intensive Care Ward Nutrition Rehabilitation Centre, Conference Hall, clinic space, food storage,and training accommodation.

CINI - Samali : Farm and Agro-based Training Centre - Poultry, fishery, dairy and agricultural units. Demonstration Centre for Village Extension Work and Supportive activities for income generation schemes implemented through MahilaMandals.

CINI - Moyna: An integrated MCH programme based on the homeopathic system of medicine, and other community development projects especially weaving project.

CINI - Chetna: Training Centre for health and rehabilitation workers with residential facilities, classroom, and auditorium for upto 100 trainers.

B .Activities at the Field Level

Activities at the field level are essentially in the areas of health and nutrition, awareness creation and income generation. These are as follows:

1. Community Health and Nutrition

a. Maternal and Child Health Systems

i) Medical Services are provided at home level through visits by health workers, weekly static clinics at Daulatpur, Thakurpurkur and Samali, and, eight (village) Mahila Mandal based clinics. (To take care of referred cases, the severely ill children are admitted to the Institute-based Emergency ward and Nutrition Rehabilitation) Centre. Curative Services, immunization, growth monitoring, health check-up, health and nutrition education, distribution of supplementary food (Nutrimix, which is prepared at the CINI headquarters with materials obtained as foreign assistance in kind, and some locally procured materials), distribution of Vitamin A prophylaxis, antenatal care, nutrition and iron supplementation to pregnant and lactating mothers, are the services provided at home and clinic level.

Totally, in the Project area, about 50,000 -55,000 mothers and children attend these clinics every year. From among them, about 700 per year are admitted to the CINI Emergency Care and Nutrition Rehabilitation Unit.

ii) Training of informal community health workers is given to suitable persons from women's groups, school teachers, community leaders, local dais and village practitioners. During the training they are taught to undertake primary care activities in the village for MCH. CINI also runs a certificate course in MCH for motivating youth in order to initiate voluntary efforts for MCH so that the community becomes self-reliant in MCH. Nutrition education, ORS awareness, and, identification of common childhood illnesses and malnutrition, are the thrust areas in training.

iii) Referral Services: CINI, in addition to providing its own first level referral hospital at Daulatpur for admission of seriously ill or malnourished children and mothers, also has rapport and effective referral facility, both forward referral for managing the crisis and backward referral to CINI for follow-up and rehabilitation of the discharged child. Referral services are availed from the local PHC, the Sub-divisional Hospital and hospitals in Calcutta City.

iv) Child Sponsorship and Child Development: Towards health development, and improved child health and child care practices in the family, CINI organises the Child Sponsorship scheme, under which a foreign donor, through the Christian Children's Fund, sponsors one child in a family. Assistance in cash and kind are provided including clothing, winter clothing, school uniforms, medical facilities, and other accessories for education and development of the child. Along with this the family also gets some other benefits, and is involved with the concept of child care and child survival. By this activity, CINI spreads the concept of "Child Survival" and also is able to properly channelise foreign assistance for child development.

v) Ambulance services: CINI offers the use of its vehicles to transport seriously ill patients in the project area to nearby city based hospitals when required. This service is offered at a nominal cost to cover fuel expenses.

b. Publications: To compliment training for MCH, several manuals, booklets,leaflets and flip charts have been published mainly in the local language. Health Education material like flip charts, flash-cards, slides, etc., have been produced.

c Research and Evaluation: One of CINI's primary objectives is to carry out relevant research in MCH. Several research activities have been undertaken in collaboration with the Indian Council of Medical Research and Nutrition Foundation of India.

2. Community Organization and Development

a Community Organization

Community organization chiefly revolves around organising Mahila Mandals since women are recognised to be the key human resource, not only for maternal and child health development, but also as providers of health to the entire family.

So far, about 26 women's groups have been organized in the project area by selecting motivated women, and training them to organize women in their area for health and developmental activities. Their activities include.

i) MCH Clinics - Organising weekly clinics, arranging for space for the clinic, etc.

ii) Balwadis (Informal School Education)

iii) Women's literacy programmes

iv) Income Generation Activities

v) Savings promotion

vi) Health Education

The Mahila Mandals select village women for training in poultry, fishery and agriculture; provide support to women starting these income generating activities after training, such as assistance in getting a loan; mobilize local savings to give loans to needy mothers, etc.

b Community Development: CINI organises literacy programmes, safe water supply, road construction, etc. In addition, at the CINI Samali Unit where the institutional farm is located, training is given in various farm activities such as improved methods of cultivation, dairy-keeping, poultry management, starting and running a fishery unit, vegetable production, training in construction of smokeless chulhas, etc. In addition, to training women for starting their own activities, many women are employed on the farm for production activities.

A weaving project for training-cum-production at Moyna provides a stable occupation to about 35 families who work at home and supply the goods to CINI. The cloth produced is partly sold, and partly distributed under the Child Sponsorship Scheme and other schemes to the beneficiary families. Similary a goatery project, fisheries project, pigery project etc. are run on similar lines with the objectives of training as well as providing employment and generating income for CINI.

3. Training Activities

CINI runs extensive training programmes on the basis of its experience and expertise in running MCH services at the community level, and community development activities. It has,in recent years, evolved as a major regional centre for training of mother and child health care workers.

a) Formal Training Programmes:

i) Training Programmes are regularly conducted for the Government ICDS programme in - training to Anganwadi workers, supervisors (Middle level) and trainers of all other Anganwadi training centres (in West Bengal). It is the only training centre for ICDS middle level functionaries in West Bengal. Besides, training ICDS functionaries for West Bengal Government, some programmes for Government of Orissa, too were conducted.

	Duration of Training
ii) Mahila Mandal Workers	for ten days
iii) Dais (Traditional Birth Attendants)	for ten days
iv) Village Practitioners	for seven days
v) Community Leaders	for four days
vi) Local Youth	for four days

vii) Training Course on National Programme on Improved Chulah

b. Informal training is given to local volunteers, Mahila Mandal Workers, and persons from the voluntary organizations.

4. Disaster Relief

Disaster reelief was one of the objectives of CINI in the early years of its formation, and continues to be so. The examples of relief work done by CINI are:

i) Assistance to victims of the Andhra Pradesh cyclone in 1977

ii) Flood relief work in 1978 in Midnapore District,West Bengal

iii) A team of doctors and nutritionists sent to Thailand during the Kampuchean refugee crisis in 1979.

iv) Famine relief work in Karamoja, Uganda in 1980

v) Cyclone relief work in Sundarbans, West Bengal.

5. Support to other Voluntary Organizations

CINI supports other voluntary organizations in various ways. Some rural health projects like the Baikunthapur, Sishu Seva Kendra, Rural Health Development Centre at Itahar in Malda District were initially started as CINI projects, and later on, became independent organizations although they continue to receive financial help from CINI.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The Child in Need Institute is a registered private charitable institution and functions under the leadership of the Director, Dr S N Chaudhuri and the guidance of the CINI Governing Body consisting of seven members. Dr Chaudhuri is assisted by an Assistant Director who is responsible for administraion and two other Assistant Directors who are responsible for training and research. In addition, ten Project Officers, each responsible for each technical area, complete the core team of staff. They have a variety of professional skills and they organize and manage the programmes. The total number of staff comes to about 200.

Dr S N Chaudhuri with his dynamism,vision and leadership has been able to attract large number of staff who are paid relatively low salaries compared to the Government and other organizations. The leader is planning to withdraw from the Project within a few years. The process of delegating responsibilities and developing the second -line leadership is going on.

PROCESS OF COMMUNITY PARTICIPATION

The community largely participates in the form of acceptance of services - curative, preventive, promotive and developmental. The activities of the Mahila Mandals organised for MCH and community development,particularly women's development, are chiefly supportive in nature, and to some extent participative, in the CINI programme.

a) Supportive activities by the Community

1. The community avails the outpatient and inpatient services on payment of token fee of 0-70 paise (or Rs.6/- for a fifteen day period) for O P D Care. Mothers collect the nutritional supplement "Nutrimix" packets prepared by CINI at a token cost of 0.50.(All these charges are waived in case of patients who cannot afford to pay.)

2 .The community avails the training, income-generation service and other facilitatory services,rendered by CINI for development. Many families are employed on the CINI's production-cum-training agriculture and cottage industry units. Some income for CINI is generated from these units.

3. Families of sponsored children, under the Child Sponsorship Scheme avail the facilities, and create health consciousness in their neighbourhood.

Thus the community contributes to a part of the budgetary requirement in the form of token fee for services, working in the economically productive units of CINI, etc. In 1979, the contribution from the community for services and

production activity at CINI amounted to 7.8% of the total budgetory requirement of CINI. This proportion has increased to 23% of the annual budget in 1985, which itself had increased sixfold by 1985. This indicates increasing participation of the community in the CINI project.

b. Active Participation in the CINI Programme

The process of taking part in planning and implementing the programmes has begun, and is gradually taking root under the guidance of CINI staff.

i) Mahila Mandals organised and trained by the CINI, in 26 villages of the Project area, actively participate in health and community development activities. Health education, surveillance for childhood malnutrition, follow-up, health and nutrition education of mothers of ill-children discharged from treatment, are undertaken by them. Mahila Mandals organise weekly clinic in their village, arrange clinic space, etc. Fund raising for loans disbursement for income generation, identification of women for training programmes run by CINI, literacy programmes, etc, are some activities taken up by a few of the Mahila Mandals. THree Mahila Mandals run Balwadis.

ii) About 52 trained mothers from the nearby slums in Tollygunje trained on the "Child Survival" concept, have started growth monitoring and health education in their neighbourhood.

COLLABORATION AND CONFLICTS

A. Collaboration with Government.

CINI believes that the role of Voluntary Organizations is essentially to come out with innovative approaches and to be supportive of the Government's larger programmes. Some examples of collaborative activities with the Governmental agencies are as follows:

i) CINI was requested by the Government of West Bengal to assist in Flood Relief Operations and to train Sishu Kalyans for relief operations in 1978 and subsequently too.

ii) The West Bengal Government relies on CINI as a resource centre to provide meaningful training to Anganwadi workers and supervisors, as well as to trainers of other anganwadi training institutes. Thus most of the training component of the Integrated Child Development Scheme in West Bengal is handled by CINI.

iii) Since 1984, the Ministry of Health, Government of India has been supporting in full, the health services component of CINI, which is the major component of CINI's programme. Funds are channelised through the Project Voluntary Organizations in Health (PVOH) Scheme.

iv) CINI has taken up implementation of the National Smokeless Chullah Programme under the Ministry of Human Resources Development and the Rural Landless Employment Guarantee Scheme (RLEGP) under Ministry of Rural Development, Government of India.

v) CINI organised loans disbursement to the tune of Rs.1,04,000/- under the FFDA Scheme (Fisheries and Farm Activity Development) of the Government of West Bengal in the year 1985. The loanees wers mothers trained in income generating activities at the CINI - Samali Unit.

In Moyna, CINI catalysed loan disbursement from State Bank of India and other sources to about 75 families selected by the Panchayat.

vi.) A training programme in Primary Health Care and Maternal and Child Health was conducted in collaboration with Jadavpur University.

vii) In collaboration with the Indian Council of Medical Research and the Nutrition Foundation of India, several research projects in Maternal and Child Health have been undertaken.

On similar lines there are many areas of collaboration with the government. There has been generally no conflict with the governmental agencies.

B Collaboration with other voluntary agencies is in the form of mutual assistance for planning and organizing new activities.

C. Generally there has been no conflict between the agency and the community.

RESULTS

The process of change in the socio-economic and health status of the community has been based on the service activites and community development activites.

Evaluation of impact in terms of objective indicators,or in terms of achievement of previously set targets has not been a feature of the programmes. However, in terms of the objectives of CINI, the progress achievd is as follows:

A .Maternal and Child Health

a) Almost nil maternal mortality in the Project Area.

b) As a result of training of slum mothers in Tollygunje slums near Calcutta, 52 trained mothers are doing growth monitoring, spreading the ORS Message, and ensuring immunization coverage in their areas.

c Totally for the government ICDS Scheme, about 200 Anganwadi workers, 72 supervisors, and 28 Anganwadi trainers have been trained at CINI.

B. Community Organization and Development

a) More than 26 Mahila Mandals are functioning in the villages working with CINI programmes.

b) Under the National Programme for smokeless chullahs, several villages have been declared smokeless. By March 1986, CINI had installed 10,000 chullahs to make more villages smokeless.

c) Under the promotion of income generation schemes for the rural poor, about 12 mothers availed loans for starting fishery units after training; another 12 mothers availed loans for starting poultry units, and several women purchased milch animals. As a result the family income substantially went up.

C. Multiplier Effect

The success of CINI has resulted in several small projects being stated on similar lines in West Bengal and Tamil Nadu. Initially they are supported/started as a wing of CINI and, subsequently are run independently - Bainkuntapur Seva Kendra, Rural Health Development Centre at Itahar and several other projects in Tamil Nadu and West Bengal have been started on similar lines.

D. National and International Recognition

As a result of national and international recognition of CINI's work, it was awarded the National Award for Child Welfare by the Women's Welfare Department of the Ministry of Human Resources Development of the Government of India, in 1985.

FINANCIALRESOURCES

The Project was started in 1979 with 100% funding by the foreign organization - The Loreto Sisters through Catholic Relief Services, USCC. Initially land was purchased with support from Swiss donors. In subsequent years, funds are being received from several foreign aid organizations including GOAL,Ireland; Bread for the World, West Germany; Our Lady of the Wayside, U K; Clontarf Community, Ireland and Catholic Relief Services, U K. Relief goods in kind are being received chiefly for nutrition supplementation from Oxford Mission, Mission International (Children's Aid Calcutta), Swedish International Development Authority, Christian Children's Fund, etc.

Grants were received from governmental sources -Government of India, Indian Council of Medical Research, Nutrition Foundation of India, UNICEF, Government of West Bengal, NIPCCD, etc. Funds generated from various sources through the years is shown in the abridged financial statement (Appendix).

The proportion of funding from foreign sources has gradually decreased from 100% in 1974 to 68% in 1979 and to 44% in 1985 and further reduced in subsequent years. It is noteworthy that in the years 1984 and 1985, the funds received from government for specific programmes like training and research under the various department heads, amounted to about one third of the budget. Further, funding from the community for services rendered and from the productive activities in which the community participates, accounts for a further 23% of the budget.

Most of the funds received from abroad are utilized for creation of physical facilities like building, land, equipment, etc. Recurring expenditure on account of activities is covered by locally raised funds.

FACTORS IN THE SUCCESS OF THE PROJECT

A .Organizational Factors

1.The Project was started by two persons, Dr S N Chaudhuri and Sister Pauline Prince with a clear goal of improving child health in the area. The leadership provided by Dr S N Chaudhuri,for improving child health and child survival, by raising funds from international agencies, etc., was the major factor in the success of the project. The combination of a vision of an integrated maternal and child development project in the voluntary sector, combined with an ability to expand activities accordingly, resulted in the success of the Project.

2 The ability of the leader to attract young committed professionals, paraprofessionals and other workers, to work long hours at the challenging, slow, tortuous task of community organization and development at relatively low salaries, is another factor which has contributed to success.

3 .The service base of CINI itself i.e. curative and promotive health services to children is another factor. Childhood illness and mortality is generally a sensitive issue in the community and, the CINI's initial and continued priority to treat childhood illness and rehabilitate children, gave a good entry point for the organization to gradually draw the community's participation and initiative for developmental activities. Even now, a substantial proportion of the budget is spent on supplementary food provision to various vulnerable groups through various schemes and outlets, drugs and other incidental expenditure for medical and health care like vehicles, & POL for mobile clinics, transport of emergent cases, etc.

B.CommunityFactors

1.The communist ideology prevailing in the area, had led to a certain degree of awareness among the people, which facilitated better acceptance of the CINI's activities.

LEARNINGS FROM THE PROJECT

1 .Voluntary effort for development should be developed as an important resource in the country, because, on the one hand our greatest asset, young women and men willing to be trained and in need of jobs, are under-utilized or not utilized; on the other hand, voluntary sector activities are often low-cost,replicable and highly effective. Adequate funds should be released by government for voluntary activities ; simultaneously, the government should select particular voluntary agencies with a history of success, replicability, and ability to train young women and men. Government should also fund training programmes by these agencies to develop potentials of young men and women in the country for voluntary health and developmental activities.

2 .All government programmes for children should include participation of voluntary agencies right from planning stage, through implementation,monitoring and evaluation stages, utilizing their insights and experience in the field.

3 .A voluntary agency should encourage personnel at all levels working in the organization to grow professionally as well as spiritually. A deep sense of

professional dedication and meaning in work life, should be evident in all categories of workers.

4 .Voluntary agencies should not allow themselves to become a forum for political activities.

5 .In conclusion, the chief learning is that the voluntary agencies will remain and keep complementing governmental efforts for the overall development of the community. The strengths of both voluntary and Government sector should be utilized, and each sector should come forward to overcome the weaknesses inherent in the other.

APPENDIX

TOTAL BUDGET — SOURCE OF INCOME AND EXPENDITURE OF CINI

	Total Budget during the year the year	Total Expenses during the year	Total received during (Indian)	Source of Income: Received from Govt & NGO & Comm-unity	Received from own sources	Received from &foreign donors
1. 1979 App	11,50,000	11,75,729	11,03,097	2,59,837 (23.56%)	86,000 (7.80%)	7,57,255 (68.64%)
2. 1980 App	19,35,000	19,34,000	18,70,174	6,00,000 (32.08%)	3,35,000 (17.91%)	9,35,174 (50.01%)
3. 1981 App	26,46,000	26,45,846	25,69,244	3,48,997 (13.58%)	4,83,069 (18.80%)	17,37,178 (67.62%
4. 1982 App.	30,66,000	30,65,708	30,42,848	2,66,540 (8.75%)	6.84,120 (22.48%)	20,92,188 (68.77%)
5. 1983 App	42,00,000	1,20,295	38,94,502	6,10,139 (15.66%)	8,57,910 (22.02%)	24,26,453 (62.32%)
6. 1984 App.	61,00,000	60,67,943	56,43,703	13,51,818 (23.95%)	12,13,124 (21.49%)	30,78,761 (54.56%)
7. 1985 App.	66,00,000	65,63,588	64,53,130	21,24,067 (32.91%)	14,88,143 (23.06%)	28,40,920 (44.03%)

NB: Percentage Calculated on the basis of total received
a. During the said year
b. Percentage indicated within the first bracket.

Case Study : IV

RURAL UNIT FOR HEALTH AND SOCIAL AFFAIRS-- INTEGRATED HEALTH AND COMMUNITY DEVELOPMENT PROJECT

The Rural Unit for Health and Social Affairs (RUHSA), a unit of the Community Health Department of Christian Medical College, Vellore, started a comprehensive health and community development project in K V Kuppam block of North Arcot District of Tamil Nadu. This Project was started with an objective of promoting health of the community through a multisectoral approach,providing inputs for health and socio-economic development . Another objective was, to develop a model centre incorporating the multisectoral approach to health, which would serve as a training ground in community health for medical, nursing and other paramedical students of CMC,Vellore, to prepare them as social change agents wherever they might work in future.

The health scenario in the country today, is fraught with contradictions. On the one hand, the health needs of the vast rural masses and the teeming urban slums requires health services with a preventive, promotive, multisectoral and community participative approach. On the other hand, the 20,000 doctors or so coming out of the medical colleges every year and the nursing personnel, continue to be more and more technology -drugs-patient oriented. There is little hope that the total system of medical education will change soon in the near future to provide the type of doctors needed. Change will require time, given the historic development of medical education in India, its western orientation and the technique orientation of majority of the teachers. In this scenario, the chiefs of medical colleges, and the Departments of Preventive and Social Medicine, have a great responsibility to strengthen this department and to initiate training grounds for the students, possibly on the lines of RUHSA, to prepare medical and nursing students to become social change agents when they are posted as medical officers of PHCs, District Health Officers, Public Health Nurses, etc.

The following gives a detailed account of the institutional leadership of the CMC, Vellore in initiating health development of a community, as well as, the individual leadership of successive directors of the RUHSA department in planning and implementing the programmes.

THE COMMUNITY

The community consists of a population of about one lakh of the K V Kuppam Block, served by Primary Health Centre, Vaduganthangal located in the Gudiyatham Taluk of North Arcot Dist. The Block was adopted by RUHSA as the Project area. The area of the block is 180.29 square k.m. consisting of 48 revenue villages and 84 hamlets. It is covered by scanty forest and shrubby vegetation; the Palar river flows only during the rainy season. The soil is partly fertile and in some areas fallow. Rains are moderate but the area is prone to

drought. Part of the area is fed by irrigation. All villages are electrified; communication system in the form of road and rail transport is very good.

Demographic and Health Profile

The female literacy rate prior to the start of the Project in the area was 19%. Birth rate was very high, about 38 per 1000 and children under five years of age accounted for 14.1%; infant mortality rate was about 116 per 1000 live births. Antenatal registration for check-up was to the tune of 20.7% of estimated pregnancies in the area, in the pre-project period. On the whole, the health status of the population in the pre-project period (in 1977) was similar to the rest of the country. Within the population covered, the major target population for RUHSA's programmes are women and children,the educated unemployed especially, the young people who tend to migrate to the urban areas owing to lack of meaningful employment in the traditional rural milieu. RUHSA's philosophy has been that the young people are the important human resources who must be retained in the rural community to develop the rural areas. In addition to these programmes target groups,specific programmes are directed to the socioeconomically weaker sections such as, the landless farmers and labourers, marginal farmers and small farmers.

THE PROJECT :PHILOSOPHY BEGINNING AND OBJECTIVES

The project was commenced with a planned approach to implement an integrated, multidisciplinary rural health and development programme. It was started by the Christian Medical College - Vellore with the ultimate goals of (i) Improvement of the community's welfare through training of medical and nursing students. (ii) Training, health and develoment personnel of the RUHSA organization for the development of the local community (iii) organizing and training the community (iv) using an integrated multidisciplinary health and socioeconomic development programme as a demonstration.

The Project was planned to be implemented through four phases i.e., Preparatory Phase, Implementation Phase, Consolidation Phase,and Maintenance Phase respectively.

During the preparatory phase,baseline health and socioeconomic survey was conducted and the programme was formulated based on the following principles:

a. To cover a well defined area and population with a programme for general socioeconomic development of the people

b. To ensure the people's participation in planning their own future which should be the basis of the RUHSA programmes, whether health or other programmes. Without people's participation, meaningful development is not possible.

c. The Christian Medical College Hospital (CMCH) to be involved in rural development and health as part of its social commitment to the needs of the rural communities.

d. A model training resource centre for development of human resources to work for rural health and development is necessary in India.

e. The Project should be inter-disciplinary right from the start, so as to tackle the problems of people - health, education, vocational training,and agriculture.

The specific health objectives of the RUHSA programmes were:

1. To decrease infant mortality rates by 25% from about 116 per 1000 within a reasonable period of time.

2. To decrease age specific mortality rates among children of one to four years age group by 25%.

3. To decrease birth rate to atleast 30 per 1000 and to increase the birth intervals.

4. To increase the number of people having access to health services by making available such facilities, personnel and pattern of services, as are commensurate with local resources.

5. To improve antenatal coverage of pregnant women and coverage for immunization of the children.

6. To increase the economic status of families, especially those below the poverty line, by promoting economically productive activities in rural areas, so that the migration of the youth to cities in search of jobs can be reduced.

7. To establish women's clubs, nursery schools and village advisory committees in all 16 sub-units of the RUHSA Project area, towards women's development, without which maternal and child health, and family health cannot be improved in the long run.

PROCESS OF PROJECT IMPLEMENTATION

The project was initiated in collaboration with the Government of Tamil Nadu - Ministry of Health and Family Welfare, as a result of which, RUHSA was given technical control of the Primary Health Centre at Vaduganthangal. The Project was based on the concept of the Mini Health Centre Scheme of Government of Tamil Nadu.

During the preparatory phase (January 77-December 1977) the first group of 16 Rural Community Organizers who were envisaged as the core staff of the RUHSA Programme-oriented and trained, and placed in the 16 Peripheral Service Units of K V Kuppam Block. During this period the Central Service Unit was also established.

In the implementation phase (January 1979 to December 1980), the health programme was established to cover the entire block for primary health care, though trained Community based health volunteers. Development programmes in agriculture, selfemployment, education and rural industries were introduced. For this, the chief strategy was to develop community-based volunteers with emphasis on field training with a problem solving approach. During this period, general health indicators were also regularly monitored; the financial stability for the maintenance of RUHSA was evolved through implementation of selfsustaining economic components in the health and development programmes.

In the consolidation phase (January 1981 to December 1983), evaluation of the health and socioeconomic programmes was initiated; impact assessments were undertaken and the programmes were developed in another block to test the replicability of the health programme. During this period, regular training programme open to rural health workers all over the country was started, based on the field experiences in K V Kuppam block.

From the initial staff strength of seventeen in the Preparatory Phase (i.e. the Programme Director and sixteen carefully selected and trained Rural Community organizers) the staff strength had grown to eighty by June 1979, to 132 by June 1980, and to 183 by June 1982.

ACTIVITIES

The Block has been divided into 18 peripheral service units (PSUs) each headed by the Rural Community Organizer, trained and oriented for multidisciplinary developmental programmes including health through community involvement. These PSUs consisting of about 5000 to 6000 population are the basic field units through which RUHSA implements the health and development programmes.

The activities can be classified into four categories -

a. Health Promotion

b. Socio-economic development

c. Community Organization and

d. Consultancy,Evaluation,Research and Training (CERT).

These activities are carried out under the leadership of the RCOs at the PSU level, who in turn function under the technical guidance of the six sections of the Central Service Unit functioning in an integrated manner. These six sections are the Health Section, Research and Training Section, the Social Education and Development Section,Education Section, Agricultural Extension and the Animal Husbandary Section. The activities of all these sections are coordinated by the Programme Director so that they work for long term health and development of the community rather than for short-term gains or results of each programme.

A. Health Promotion

The health services are delivered in a three tiered hierarchy:

i) The General Service Unit (CSU) is a heavily utilized curative service facility and serves as a referral hospital for the block. The O-P attendance at the CSU is about 140 per day. Over 13,000 admissions take place every year which brings the bed occupancy rate at this 630 bedded hospital to about 75%. Many of the patients are referred patients by the peripheral health care workers and the PHC.

ii) At the next lower level, Mini Health Care Centres are located in each of the 18 Peripheral Service Units, for delivery of health assistance at the rate of about one mini health centre per 6000 population. A regular weekly clinic by a qualified

doctor is held at each Mini Health Centre, and during the rest of the week the Health Aide takes care of the population assisted by the Family Care Volunteers.

iii) At the household level, primary care services are provided by the local Health Aides (HA) and Family Care Volunteers (FCV) trained by the RUHSA department. Each FCV takes care of 200 families or 1000 population. The Health Aide also attends at the Mini Health Centre to provide treatment for minor ailments.

At various levels - the activities carried out by these volunteers, are as follows:

a) At Family, Village and Mini Health Centre level by HAs and FCVs : Promotion of family planning, reduction of preschool mortality through identification and registration of under-two's for monitoring growth, immunization, health and nutrition education, control of measles, control of poliomyelitis, and registration of vital events. Measles immunization is done in collaboration with the Rotary Club of North Arcot district, antenatal care is done at the family level if necessary referring upto Central Service Unit level, depending upon the complexity of the case.

b) At CSU level: All the services offered at the lower levels are provided, and in addition, supportive services of obstetric and gynaecology , physician, etc. are offered.

B. Community Organization

RUHSA has trained 200 community based volunteers for specific areas of work i.e agriculture,veterinary,etc. These volunteers are selected from the community and they work in the community for the different programmes. These volunteers, assisted by the various cooperatives, clubs, mahila mandals,etc. carry out supportive activities for the RUHSA's programme, through health education, facilitation of acceptance of modern methods of cropping, etc. The community organizations developed in the area are as follows:

i) Women have been organized into Mahila Mandals and they are trained to assume leadership roles for mother and child health, general family health and nutrition,etc.

ii) Youth Farmers Clubs are organized to bring together progressive farmers who are interested in new ideas and farming practices. Such farmers are now helped to adopt modern practices by the Village Agriculture and Veterinary Extension officers of RUHSA.

At the peripheral service unit level the rural community organizer who is and appointed by RUHSA is a full time representative and he organizes the community into these various groups, provides support for them to assume leadership roles, selects capable persons from the village for training as Family Care Volunteers, Health Aids, Village Agriculture Guides, Veterinary Guides and Animators.

iii) The dairy cooperatives, weavers' cooperatives, the poultry cooperative and sheep breeders'Cooperatives develop their particular spheres of activity in the project area with the technical help of RUHSA.

C. Socio-economic Development

i) RUHSA in collaboration with the Government Departments has been able to introduce modern methods of agriculture, cropping with less water consuming crops, production of algae significant to ecology, self reliance in agriculture by the farmers, many high yielding crops such as jasmine, and silk worm rearing, which were implemented through participation of Youth Farmers Clubs.

ii) Promotion of three sheep-breeders cooperatives with 290 members; getting assistance for them from banks to improve and take up sheep-breeding for supplementary income.

iii) Organization of a dairy cooperative; organization of breeding service to improve the quality of local cattle through procurement, proper storage, and provision of proven frozen semen for animal husbandry; organization of a Weaver's society and enrolling unemployed people into the occupation of weaving.

iv) Training of village masons in the construction of Janatha model bio-gas plant.

v) Training to farmers in integrated water-shed management programmes through increased cropping of low- water - consuming crops such as jasmine and mangoes, in areas which previously were used for water-intensive crops such as sugarcane, banana and rice. This practice used to result in crop failure when adequate rainfall was not forthcoming.

vi) The Community Broiler Scheme, under which the farmers, a bank and RUHSA entered into a tripartite agreement - RUHSA arranging for purchase of chicks and paying for insurance coverage, veterinary services coverage, poultry immunization, and marketing; The bank provided finance at every stage; the farmers grow the day old chicks to about 8 weeks, which adds an income of Rs.200 to 500 per month with only part-time activities. RUHSA checks to ensure that the farmers repay the loan provided for purchase of chick feed and other inputs.

vii) Kitchen gardening activities have been promoted among more than 2000 families to improve family nutrition.

viii) Under the Adult Education Programmes, 29 adult Education Centres are functioning,run by Animators selected from the community and trained at RUHSA.

ix) Drought Relief: RUHSA collaborates with the Government in drought relief and rehabilitation activities.

D. Evaluation, Research and Training Activities

Training of all the categories of development and health personnel mentioned above, training of medical students and nursing students, training of rural development workers from other agencies, is carried out.

Ongoing monitoring of the health and socio-economic indicators is a integral part of the RUHSA Programmes. Action research is basic to the RUHSA programme, which was initiated with the twin idea of learning from the com-

munity about its needs, and teaching the community to have a better quality of life within the existing resource constraints.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

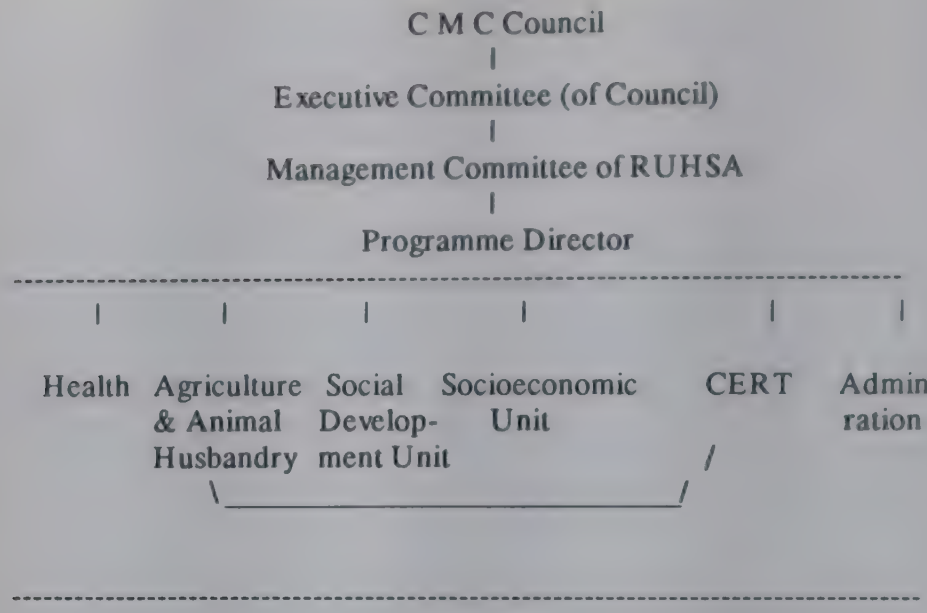
A. Organizational Structure

The RUHSA Department functions under the broad direction and guidelines of the CMC council which is composed of senior members of the Christian Medical College, Vellore. Within the framework of the guidelines, the Programme Director, Dr Daleep S Mukarji planned and implemented the programme right from the inception. Under the Programme Director, are the six sections - health, agriculture and animal husbandry, social development unit, socioeconomic unit, CERT and administration. In 1982 there were 183 staff distributed among the six sections as follows:

a. Health	-	47
b. Administration	-	57
c. Social Development	-	27
d. CERT	-	19
e. Agriculture	-	16
f. Animal Husbandry	-	9
g. Socioeconomic Unit	-	8

This includes the 18 Rural Community Organizers, the Specialists and General duty doctors,nurses, members of the mobile health team, and supervisors. Apart from these formally appointed staff, a large number of supportive grass-root volunteers trained in different fields, undertake most of the grass-root level work of enlisting community participation and widespread acceptance of the programmes of RUHSA. This informal voluntary organizational structure consists of about 80 Family Care Volunteers (one per 1000 population), 18 health aids (1 per PSU), 18 village agricultural guides, 18 village veterinary guides and 40-50 animators.

Organizational Structure of RUHSA



B.Leadership

The RUHSA programme has evolved under the able leadership of Dr Daleep S Mukarji, the former Project Director, who formulated the total plan and was able to attract a large number of motivated staff even though they were paid relatively low salaries. After the training, which he himself largely planned and organized, he was able to inspire them to perform the difficult task of community organization and participation in health and development to achieve remarkable results as shown by the health indicators in the block. Subsequently, the leadership of the programme has been taken over by Dr Rajarathnam Abel in the maintenance phase of the project.

The leadership roles in the Project can be perceived at three levels : At the top level, the Project Director provides leadrship to the total project in all its multidisciplinary aspects. He is assisted in this task by the six section heads of the Central Service Unit.

At the middle level, i.e. the PSU level, the Rural Community Organizer is the key person who leads the community and plans the activities for all the programmes in this unit. He is guided in this task by the respective Section Heads,

particularly to resolve technical and operational problems in the respective programmes.

At the village level, the community volunteers i.e. the Health Aides, FCVs, Village Agricultural Guides, Village Veterinary Guides, and Animators, provide the leadership for mobilizing the community to participate in the respective programmes. These community volunteers are guided by the RCOs, and also the other Central Service Unit staff when they make field visits.

COLLABORATION AND CONFLICTS

The entire project has been conceived to start in collaboration with government and is being implemented in close collaboration with the Government. RUHSA Department has technical control of the PHC attached to the area. Collaboration with the banks for financing the developmental activities, collaboration for implementation of integrated water shed development schemes and social forestry, liaison with government under the food-for-work programme during the drought period 1980-82 for drought programe,etc., are some instances of collaboration with the Government of India and the Government of Tamil Nadu, towards running the Project.

There has been no significant conflict with the community or other voluntary agencies.

PROCESS OF COMMUNITY PARTICIPATION

A. Health

i) The community avails the health services provided by the RUHSA at various levels from the family care level, the Mini Health Centre Level, the Primary Health Centre level, and the Central Service Unit. The Health Aids and Family Care Volunteers are voluntary health workers from the community to take care of home treatment of scabies and diarrhoea, recording and monitoring vital events in the community, monitoring of maternal and child health, motivation for family planning, immunization, and similar services. The Mahila Mandals also work in the community chiefly to educate the people to live a healthy life style and to take prompt action in case of ill health.

B. Socioeconomic Development

The facilitatory services provided by RUHSA in terms of technical know-how; training for communication with the people in the various fields of health and development are availed by the community, in the sense that, sufficient number of volunteers (about 97 health workers, 18 VAG's, 18 VVG's and 29 Animators) have been trained and work in the community in the respective fields. This has resulted in a marked change in the community in terms of well-being and health indicators.

At the village level 18 Village Advisory committees (VACs), 51 Youth Clubs, 10 Yound Farmers Clubs, and 27 Women's Clubs function as channels of communication with the community and forums of development. A great many

families derive supplementary income owing to the developmental activities and this has undoubtedly improved the quality of life and nutrition available to the people, as is evidenced by reduction in the prevalence of malnutrition in children and better health status of the population. Thus, with a little material input by the RUHSA, chiefly by the sheer process of facilitation and community organization, the community has begun to participate and take responsibility for its health and development, without which a significant change in health status is not possible.

RESULTS

The process of change in health and socioeconomic status of the K V Kuppam Block was based on a strategy of training multidisciplinary workers (the RCOs) to implement the health and development process in an integrated fashion in the community, shoulder to shoulder with trained volunteers, selected from the community and living within the community.

The initial entry point has been health, particularly maternal and child health. An extensive health network was implemented backed by skilled referral services at the CSU and the Medical College Hospital, for bringing down maternal and child deaths. This provided an acceptable entry point for introducing preventive health programmes and community development programmes.

Basically the change process has been initiated by a strategy of promoting health and development through appropriate technology transferred to the community through agents acceptable to the community-trained volunteers selected from the community living within the community . The focal point around which community organization and development has been fostered, has been the Rural Community Organizers, trained in communication skills and motivated for community organization. The results in terms of community health and development have been remarkable, and are listed below:

A. Health

The health indicators show major changes in the period 1977 to 1986. The crude birth rate has declined from a pre-project level of 38 per thousand to 22.9 in 1986; the infant mortality rate declined from 116 per thousand live births to 65 in 1986. The proportion of underfive children in the population declined from a level of 14.1 % of the total to 9.7% in 1983. The crude death rate declined to about 8-9/1000. The incidence of poliomyletis was reduced from a rate of 0.3 per thousand children per year to 0.02 per thousand children due to immunization. Similarly measles, which annually strikes 150/1000 children per year in the rest of the country, has declined very much in K V Kuppam Block, where it strikes about 14 children/1000 per year.

Antenatal registration has increased from about 20% coverage of eligible mothers in 1978 to 54.8% in 1981 and more, subsequently. The number of tubectomies annualy performed at the Central Service Hospital has increased from 97 in 1978 to about 700 in 1982.

B. Socio-economic Development

Six hundred and fifty nine families below the poverty line have benefited from the bank loans. Although in terms of income there is no remarkable improvement, the increased productivity of families for self-consumption has improved the quality of life. On detailed scrutiny of the beneficiaries of all programmes of RUHSA, it was found that 73% of the families below the poverty line received the outreach services (health, animal husbandry, education,social development or agriculture) and 54% of families above poverty line were reached by one or the other of programmes.

On survey of the families by questionnaire method, during the evaluation survey in 1982, 37% of the families felt that they had improved their income, 29% of families expressed that their living conditions had improved, 22% felt that their total well being had improved. Considering health conditions, 58% of the population of K V Kuppam felt that their health conditions were very much improved. This suggests that the Programme has made significant impact on the community.

FINANCIALRESOURCES

The RUHSA programme of community development especially to serve the weaker sections, began with substantial inputs from external sources. Expenditure has been increasing and further the community's share of bearing the expenditure has been decreasing. From an initial budget of Rs.5 lakhs at the start of the Project in 1977, it has grown to Rs.35 lakhs in 1986. In 1981-82 project the Christian Medical College provided Rupees one lakh for RUHSA and the preceding three years too Rupees one lakh per year was provided towards the recurring expenditure. Out of a total expenditure of about rupees 20 lakhs in 1981-82, the income generated from within the project through payments for health service, socioeconomic activities and agriculture was rupees five lakhs, (approximately 25% of the total budget), government grants from the Government of Tamil Nadu accounted for Rupees three lakhs or about 14% of the budget . That is out of the recurring expenditure, self generation of funds by the project was of the order of 25% and the rest was in the form of external inputs to the community. External inputs also include trusts and endowments, receipts from overseas and international agencies, and foreign donors.

In 1985-86, the recurring expenditure had grown to rupees 35 lakhs of which only 12% was accounted for by the community.

FACTORS IN THE SUCCESS OF THE PROJECT

1. Positive Organizational Factors

i) The service orientation and clinical skills and capabilities offered at the Base Hospital of RUHSA greatly facilitated its acceptance as a change agent by the community. The committed and extensive network of health services combined with highly skilled referral backup by the Base hospital and the famed Christian Medical College hospital at Vellore, gave the project a great deal of impetus and weightage in the community.

ii) The committed leadership of the Programme Director, Dr Daleep S Mukarji, who was able to create conditions for village based rural technology programme, from a setting of high technology, medical care oriented hospital-cum-medical college.

iii) The ability of the leader to recruit and attract committed health professionals and para professionals, social workers and other related developmental workers, and motivate them to work on the tough task of organising the community inspite of low sal aries.

iv) The strong institutional and financial backing given by the Christian Medical Council which could stand guarantee for extensive expenditure, was utilized for the rapid socioeconomic and health development in K V Kuppam block. The annual expenditure on a per family basis, worked out to rupees 80 per family per year by RUHSA which is in addition to all the government expenditure in the block, which is also fully utilized by the RUHSAs facilitatory activity.

v) The stress on female literacy and women's development in the overall strategy of RUHSAs programme which enabled female literacy to rise from 19.1% to 31% within a short period of about five years... Female literacy has been consistingly associated all over the world with better family health as well as maternal and child health and improved family planning acceptances. Here too, the increased literacy has been accompanied by higher acceptance of family planning, and reduced birth rates.

2. Organizational Constraints Experienced in the Project.

In the course of evaluation, an opinion poll among the staff of RUHSA was taken in order to understand what were the con straints which could have reduced the impact of the project. These are rank-listed by the order of frequency as follows:

a. Lack of coordination and inadequate orientation given to staff, particularly to new staff (97%)

b. Prestige issues among the senior officials within and between units (64%)

c. Lack of good relations between field staff, CSU staff, Health Unit Staff, and communication gap between CSU and PSU (27%)

d. No proper recognition to rural community organizers

e. Less frequent visits of senior officials to various units.

LEARNINGS FROM THE PROJECT

1. It is recognized by the Project leadership that, while the RUHSA was established as an expression of the commitment of the CMCH to serve the poor and the rural area, the intensive nature of the Project including staff pattern with intensive training, highly skilled and highly motivated professionals, high investment, etc. are not readily replicable if we have to consider the replicability of the project as a whole in the rest of the country. The expenditure per family by the Project itself comes to much more than Rs. 80 per family per year in addition to

all other governmental inputs, budget outlays, loan facilities,etc. for the area. How far could such a additional inputs be made, which imply huge outlay, quite apart from the intangible services and moral support of the famed Christian Medical College Vellore?

2. The RUHSA Project however, has provided an example of what a sophisticated medical college organization can achieve in implementing health care activities in a rural area. The government of India expects each medical college to be involved in the primary health care of three blocks. The medical colleges all over the country could draw from the experiences of RUHSA to plan their primary health programmes in the rural area.

3. A leadership, committed to rural development combined with the commitment to develop second line leadership in the organization and in the community, is required for true development.

4. One of the most important lessons is that intervention in health-cum-socioeconomic aspects will pay off rich dividends. This point should be seriously considered in planning for our strategy to achieve health for all by 2000 AD.

5. The strategy for transfer or application of appropriate technology in the area of rural health and development, adopted by RUHSA is one of the chief lessons which it has to offer. The organization, training and establishing of pivotal persons, the Rural Community Organizers, one for every 6000 population who oversees the grassroot level workers, himself trained for multidisciplinary work at the village level, (health, agriculture, and several other activities),has been crucial to the success of transfer of technology to the people. This strategy is replicable in government and other voluntary agency programmes.

6. In the literacy programme, the concept and implementation of mobile libraries in adult education programme are replicable elsewhere.

Case Study: V

RURAL HEALTH RESEARCH PROJECT - MANDWA

Mandwa is a small village in North Alibag taluka of Raigad District of Maharashtra, across the harbour from Bombay. In 1972, Dr N H Antia and Mr N P Godrej an industrialist, who were closely associated with the Society for Reconstructive Surgery, Rehabilitation and Research at Bombay, decided to initiate the Rural Health Research Project with its base at the village Mandwa. Soon, the Foundation for Resarch in Community Health was established to take over the management of the project under the guidance and leadership of Dr N H Antia. The Foundation has involved the State Government from the very beginning and has sought to implement a primary health care programme through Primary Health Unit Staff paid by the government, assisted by a community based cadre of village health workers. The successful achievement of the HFA Goals within less than a decade through the strategy of using village health workers, with very little additional investment, has shown that HFA can be achieved without marked change in socio economic status, primarily by the efforts of the health sector. The following gives an account of the success and limitations of this model of community participation for health.

THE COMMUNITY SERVED

The Community served by the Mandwa Project at its inception in 1972, consisted of a population of about 30,000 living in 30 villages of North Alibag Taluka of Raigad District, across the harbour from Bombay. At the start of the Project the following characteristics of the population were observed.

i) General

The major occupations of the people are, agriculture and fishing. Availability of land for agriculture is limited due to high soil salinity, hilly terrain and many creeks. Owing to poverty most of the had one or two members employed as petty labourers in Bombay. Dairy farm and poultry supplemented their income to some extent.

ii) Health Profile

Prior to the start of the Project, malnutrition, inadequate water supply and lack of sanitation were the rule, with resulting high prevalence of "diseases of poverty" gastroenteritis, scabies, worm infestation, malaria, tuberculosis and leprosy. Other common ailments such as colds, aches and pains, and minor injuries accounted for the remaining causes of morbidity in the area.

iii) Availability and Accessibility of Health Services

The Government health services consisted of a Government dispensary about five or more miles from the Project villages. The dispensary was supposed to be manned by a doctor and a nurse Both of them hardly visited the dispensary and usually charged a fee for government drugs. Besides this, the Primary

Health Centre of Poynad, situated about 20 miles away from the area, was expected to "cover" the project villages for preventive health services. Two subcentres were situated within the Project area, but owing to poor supervision, the ANMs and male workers worked erractically and did not really provide health care to the community.

Nine registered medical practitioners (none of them with an MBBS degree) practised in the area. With poor knowledge of allopathic drugs and yet extensively using them, and with their exploitative practices, these doctors were hardly an asset to the community as far as health care was concerned. The District Headquarters Hospital at Alibag, about eleven miles from the Project villages, was connected to the villages by State Road transport buses. A ferry service could also take the people across to Bombay in case an emergency need for medical care arose.

Thus in terms of accessibility, there was virtually no health service accessible to the people. Some illness services provided by the Government doctor and nurse for a fee, or by the registered medical practitioner, constituted the health services of the area.

The health indicators in the area in terms of birth and death rates, infant and toddler deaths, etc., were of the same order as the national averages.

THE PROJECT : PHILOSOPHY, BEGINNING AND OBJECTIVES

During 1971-72, Dr N H Antia a plastic surgeon specialized in reconstructive surgery for leprosy victims, who was also associated with the Society for Reconstructive Surgery, Rehabilitation and Research in Bombay, became increasingly concerned with the widening gap between the health services and the people. While the health personnel became more and more technique-oriented and urban-oriented, the people's health problems, majority of which were preventable and often lethal, continued to take their toll. Mandwa project was conceived to provide a model of an alternative, rural, accessible health care system through community participation and through creating a community-based cadre of health workers who would be the link between the community and the doctors. The emphasis would be on empowering the community to deal with most of its health problems, which would result in much better health status at a much lower cost.

In association with Mr N P Godrej, Dr Antia launched the Rural Health Research Project in North Alibag Taluka, which he visited frequently during 1971-72 to crystallize his ideas on formulation of the project.

The objectives were as follows:

1. To develop an alternative for rural health care based on the community participation, which could be replicated in other areas.

2. To select, train and field, village health workers (VHWs) in the villages of North Alibag as the chief means of promoting community participation and self help.

3. Using the VHW as the foundation, to develop an efficient supportive health structure in the villages, offering simple curative, preventive and promotive health services.

PROCESS OF PROJECT IMPLEMENTATION AND EVOLUATION OF THE PROJECT

1. The first step was to promote these whole new set of concepts in the community. Preventive health action, community participation in the health system financing and for health actions, village-based trained health workers as providers of basic curative services, all these were concepts which were not readily understandable to a community which wanted to receive health services free of cost on a charitable basis, and a community which believed that health care consists of more doctors, more drugs and large hospitals in or near their villages. Most of the people apart from the rich and influential few, were primarily concerned with how to get the next meal; when illness prevented this, the priority was to get quick relief, to enable them to go back to work. So health promotion and disease prevention did not come anywhere near their list of priorities.

Towards the difficult task of convincing the community, organizing them for community participation, enlisting support of the community leaders and gram panchayats, both financial and otherwise, a community organiser was appointed in 1972. He was a young motivated graduate of the Tata Institute of Social Sciences who had specialized in Community Development and came from a rural background in Maharashtra. He began the task of enlisting community support. Soon after, in 1974 a young MBBS doctor who was also of rural background and motivated to work for the village poor, was recruited. He began to conduct the clinic in Mandwa village and to motivate the community leaders to participate in the project for community health.

2. Following the spadework by the Community Organizer, 13 Gram Panchayats agreed to sponsor Village Health Workers (VHWs) and to pay half their monthly honorarium of Rs.50/- each. In consultation with the gram panchayats, suitable women who were motivated, mature and intelligent, though not necessarily highly qualified, one from each village were selected and trained at a local school for ten days. MCH treatment of minor ailments, record maintenance and referral were the major areas of training.

3. Simultaneous to recruiting VHWs, a Project coordinator was recruited to coordinate the entire activities of the programme, namely, curative, preventive, promotive, training, supervision and community participation aspects of the programme. In addition an Administrative Assistant and Research Officer were recruited for administration and research aspects respectively.

4. Next arose the need for better health facilities than the out-patient clinic at Mandwa manned by the Project doctor. It was felt that a health centre should be started with operating theatre, inpatient beds, and, infrastructure to implement malaria control programme and family planning programme, provision of some kind of first level referral services such as minor operations, inpatient I-V rehydration, etc. This was a felt need of the community.

For this, after much perseverance, an agreement could be arrived at between the Foundation, the Kolaba Zilla Parishad and the State Directorate of Health Services, that a Primary Health Unit would be established, keeping in view the relative isolation of the project area from health services. For this the Government would place the budget, staff and drugs at the disposal of the Project. The Project leaders contacted the community leaders for getting five acres of land donated by Dhokawada and Saswane Village Panchayats. Finances were obtained from the Volkhart Foundation,(for construction of the hospital), and the Primary Health Unit with the above mentioned services were set up.

The PHU was manned by the usual pattern of goverment staff one medical officer, two ANMs, a compounder, supportive staff and malaria workers. These staff while working under the coordination of the project, received their salaries from the governement and were recruited by the usual governmental procedures. In addition five ANMs and some additional supportive staff were recruited by the Foundation.

Thus, in the final state, the Project Health Service assumed the form of a government health facility managed by a voluntary agency, with additional staff, management inputs, and direction by the project leaders. Another feature was the community participation enlisted by the Project staff. The community based VHWs were also organised and maintained by the Project, as also coordination of their functions. Research work is an additional function carried out by the project staff with the help of data generated by the VHWs and PHU staff.

ACTIVITIES

A. Health Care Services:

1. Curative Services

a) Curative services at village level are provided by the VHWs for minor ailments, including Oral Rehydration Therapy for gastroenteritis, treatment of coughs and colds, minor injuries, deworming, scabies, presumptive treatment for malaria, maintenance of drug regularity of leprosy and TB cases. In addition, VHWs refer cases not responding to their treatment,suspected cases of leprosy and TB to the PHU.

b) The ANM treats referred cases, carries out routine antenatal check-up, and undertakes treatment of TB cases.

c) At PHU level, the doctor treats referred cases, conducts pathological tests, difficult delivery cases,antenatal cases referred by the ANMs, minor operations, and operations are conducted with the help of visiting surgeons from the District Hospital at Alibag.

2. Preventive Services

The VHWs maintain records of all vital events in the community including maternity cases, births, disease and deaths, information on eligible couples, children eligible for immunization, and underfives. In addition, VHWs are trained in chlorination of wells and construction of soakage pits which they undertake with the involvement of the community. With the information provided by the

VHWs and the motivation provided to the community to demand services, the ANM's tasks of conducting antenatal check-ups, immunizations, examination and identification of at-risk antenatal cases and underfives, motivation of eligible couples for family planning, are all facilitated during her twice -weekly visits to each of the five villages in her area.

In addition, the VHW ensures drug regularity of TB and leprosy cases. The community is motivated to cooperate with the to staff and to demand malaria spraying operations, which are carried out by the Government malaria workers, whose work is thus facilitated by the VHWs and ANMs.

Two male community supervisors, trained by the community organizer, assist the VHW in record maintenance and in promoting community participation in health practices.

B. Socioeconomic Programmes

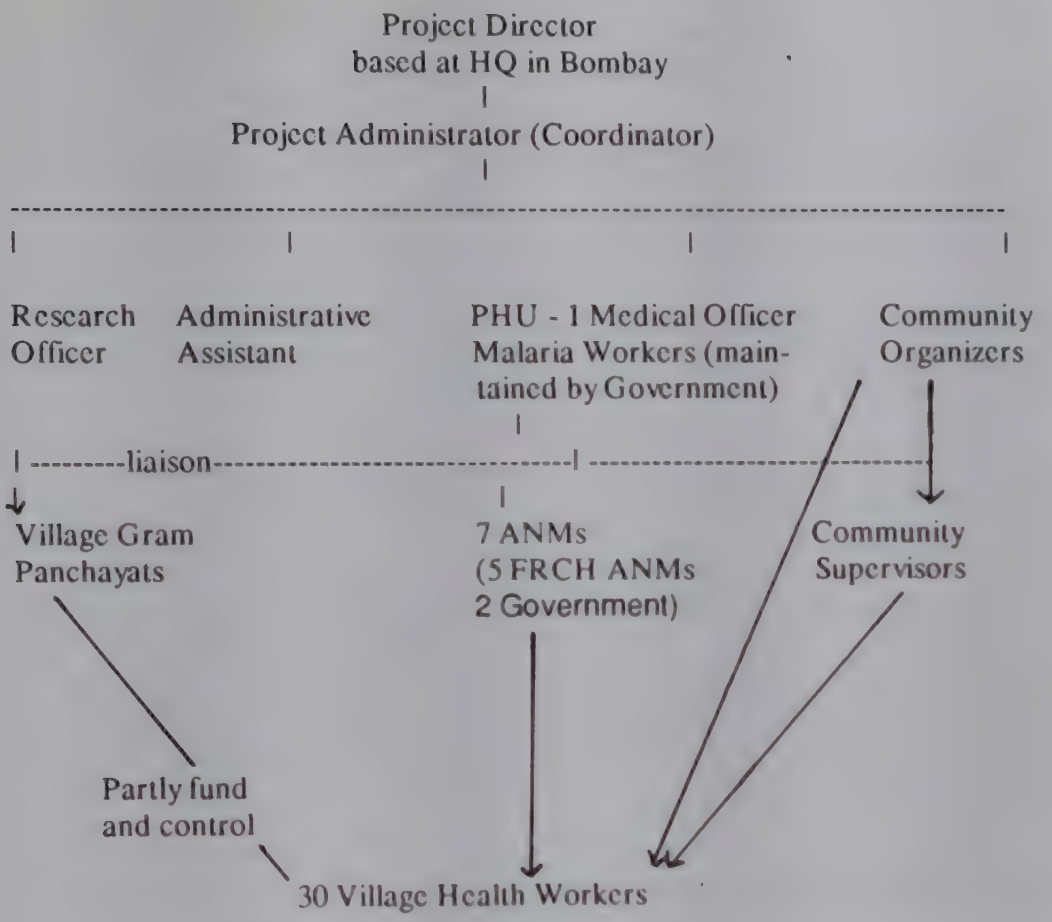
An attempt was made to integrate the health services with socioeconomic development programmes, initiated under the supervision of an Economic Development Officer. It was visualised that with his supervision and technical guidance, the Community Organiser, doctor and other health staff would serve as facilitators and links with the community, and the community itself would participate as the prime implementor of the programmes.

However, each of the programmes whether the supplementary income scheme, agricultural development programme, sanitation programme or energy programme, required much more village organization, cooperative spirit, and much more effort from the project staff than they could provide, given the staff pattern and the umpteen programmes attempted. This resulted in dilution of efforts to a remarkable extent, so much so, that during an attempt to evaluate the whole project in 1976, the lack of systematic work in even one any showed up. This demoralised the whole staff; large scale resignations took place, and a major crisis set in. At this point, the socioeconomic programmes were abandoned except to provide facilitatory services to put the villagers in touch with the concerned governmental agency.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The overall vision direction, and moral sustenance has been provided by Dr N H Antia, who steered the Project through the initial phase of evolution, the crisis of 1976-77 and subsequent stabilization of the Project in 1978-80, which continues till date. The organizational structure of the Project is as follows:

Mandwa Project Organization



Thus the middle level leadership to implement the Project is provided by the Project Coordinator who coordinates all activi ties of the project. The staff pattern of the project, by source of funding, is shown in the following table:

MANDWA PROJECT STAFF-FRCH AND GOVERNMENT

Designation	FRCH	Government
Doctor	--	1
Community Organiser	1	--
Community Supervisors	2	--
Auxiliary Nurse Midwives	5	2
Compounder	--	1
Sanitary Inspector	--	1
Vaccinator	--	1
Attendant	4	--
Driver	1	--
Clerk/Typist	1	--
Village Health Workers	28	--
Watchman	2	--
TOTAL	44	6

PROCESS OF COMMUNITY PARTICIPATION

One of the chief objectives of the Project was to elicit community participation from the stage of planning the programmes to implementing the health services, and to make the community self reliant for health. However, in the process of forming a Central Health Committee of community leaders to direct health actions, it turned out that the influential and politically powerful constituted the Committee, who wanted investment to be made on more sophisticated curative care for themselves, rather than participating in and directing a larger health plan for better health status of all the villagers. Hence, after the initial formation of committees, donation of community land for the PHUs, and commitments of the Gram Panchayats to pay part of the honorarium of the Village Health Workers, the involvement of the community and its leaders in planning and execution of the health activities has been minimal. Attempts to utilize the community organization for socio-economic programmes such as sanitation, agriculture, etc., have either failed completely or met with partial success, because of factionalism on account of caste factors, or simply, on account of lack of adequate community involvement.

The major visible result of the community participatory approach to health, has been the firm establishment of the village Health Worker in each of the villages, who, being a person of the Community, carries out the health activities as per expectation. Also the Gram Panchayats are continuing to bear half the cost of their honoraria which is evidence of their continuing participation.

COLLABORATION AND CONFLICTS

A. Collaboration with the Government

1. The Project was initiated in close cooperation with the State Government of Maharashtra and the Kolaba Zilla Parishad. The State Government sanctioned a Primary Health Unit for the Project Areas, for which budget for recurring expenditures namely drugs and staff and other consumable items are provided by the State Government.

2. Thirteen Gram Panchayats in the area pay 50% of the honoraria of the Village Health Workers.

3. The Research wing of the FRCH in collaboration with the Indian Council of Social Science Research and the Indian Council

of Medical Research organized a study group on health care which resulted in the document "Health for All - An Alternative Strategy". This contributed to the formulation of the Health Plan in the Sixth Five Year Plan.

Generally there has been no conflict with Governmental agencies.

b. Collaboration and Conflicts with the Community

Generally there has been no conflict with the community. The community has been responsive to the services providedd and availed the services.

RESULTS

The change process has been based on a strategy of training, supervising and guiding community-based health workers on a continuous basis. In addition, systematic management by the FRCH administration to *ensure* functioning of the PHU and the Auxiliary Nurse-Midwives, has resulted in success, *in a context almost similar to the existing pattern of Government health services in other parts of the country.* This project illustrates how a sustained leadership committed to health care for the villages could achieve admirable success virtually in the context of a government health system with some additional voluntary effort for community participation.

The result has been a remarkable change in the health and family welfare status in the population. The following table showing the health, family welfare and health service indicators of the area compared with the national averages, illustrates the gains in health status.

Progress of Mandwa Project-Health Statistics 1977 & 1980, & Comparison with National Figures

	INDEX	MANDWA PROJECT 1977	1980	NATIONAL FIGURES (1980/OR Nearest Year)
1	Birth Rate	13/1000	19/1000	33/1000
2.	Crude Death Rate	7/1000	5/1000	14/1000
3.	Infant Mortality Rate (per thousand live births	N.A.	66/1000	122/1000
4.	Infant Mortality as percentage of total deaths	N.A	25%	24%
5	Toddler death as percentage of total deaths	N.A.	5%	15%
6.	Ante-natal Care:			
	a) Number of ANC Cases	577	710	N.A.
	b) % of ANC cases immunised with tetanus toxoid 2nd dose	55%	78(1982)	32% *
	c) % of ANCs receiving diet supplements	N.A.	90%	60% *
7.	Maternity Services:			
	a) % of deliveries conducted by:			
	i) Trained staff (Doctor,ANMs VHWs and Dais)	11%	29%	29%
	ii) Untrained persons	89%	53%	80% (est.)
	iii)Private nursing home	--	18%	--
	b) % of deliveries conducted at:			
	i) Home	89%	61%	90%
	ii) Hospital/PHU	11%	39%	10% (est.)

8. Post Natal Care: % of deliveries receiving post natal care	69%	96%	N.A.
9. Immunization:			
i) Small pox Primary	88%	65%#	N.A.
ii)Tripple Antigen	N.A.	92%(1982)	28% *
iii)BCG	N.A	N.A	N.A.
iv) Poliyomyletis	N.A.	67%(1982)	--
10. Curative Service			
i) Total number of cases treated	11500	13107	N.A.
ii)% of cases treated by			
a. VHWs	14%	21%	--
b. ANMs	23%	38%	--
c. Doctor	63%	41%	--
11 Leprosy Control:			
i) Total Number of Old cases under treatment	111**	145**	--
ii) Total number of new cases under treatment	25	7	--
iii)% under regular treatment	60%	80%	--
12. Tuberculosis Control:			
i) Total number of old cases	79	93	--
ii) Total Number of new cases	20	28	--
iii)% under regular treatment	75%	76%	--
13 Family Planning:			
i) Total number of eligible couples	N.A.	805	--
ii)% of above sterilised	N.A.	17%	21%(1977)+
iii)% of ECS using contra-ceptives	N.A.	20%	3% (1977)+

* - Draft Sixth Plan, Vol.III
** - At the beginning of the given year
\# - Discontinued in mid 1980
\+ - Dr Banoo Coyaji, 1978; Family Planning Policy 1979-99 Health and Medical Services Committee, Bombay

FINANCIALRESOURCES

The Foundation for Research in Community Health runs the Mandwa Project through its own funds received through donors, and the budget allocated by the State Government of Maharashtra as well as the Kolaba Zilla Parishad, for the recurring expenditure of the Primary Health Unit at Dhokawade. Initial expenditure for construction of the PHU was borne by the Volkart Foundation, an overseas funding agency.

The breakup of the annual recurring expenditure of the Mandwa Project is as follows:

Annual Recurring Cost Of FRCH on Account of Mandwa Project(1980)

	(in rupees)
Salaries	1,16,931.00
Drugs	19,346.00
Transport	36,230.00
Special Programmes(Nutrition, etc.)	3,395.00
Electricity, rent, and taxes	3,741.00
Repair & Maintenance	2,109.00
Postage, printing and stationery	9,835.00
Miscellaneous	4,982.00
TOTAL	1,96,569.00

i.e. approximately Rs.6/- per capita per annum.

FACTORS IN THE SUCCESS OF THE PROJECT

A. Positive Factors

1. The leadership provided by Dr N H Antia, who steered the Project through difficult times during the early years was largely responsible for the success of the Project. Again, when an attempt to integrate community organization for health with socio-economic programmes failed to take root, the leadership could take timely decisions to abandon programmes undertaken beyond the Project's scope and capabilities.

2. Systematic training, encouragement and supervision to persons of average calibre who were recruited, resulted in effective utilization of their services. The staff pattern was by and large similar to the Government Health Services elsewhere in the country, and in fact most of them were recruited and paid by the Government. Yet some input of management and leadership could enable these very staff to bring forth remarkable change in the health status of the community.

3. Reliance on local persons for bulk of the preventive health care especially the VHWs, has been one of the great strengths of the project. In 1977, a local BAMS graduate (Ayurvedic physician) who was recruited for the PHU has also proved to be a committed health worker and an asset to the Project.

B. Negative factors and Constraints

1. Difficulty in getting a motivated MBBS doctor to work in rural areas for Primary Health Care without sophisticated medical equipment, was one of the chief factors, hampering the ability of the PHU to function as a first level referral hospital. *Frequent turnover of doctors, and finally the need to place a doctor of Ayurvedic medicine* in the PHU has reduced the middle level leadership inputs to some extent, and reduced the community's satisfaction and also resulted in limited community participation.

2. Another problem was the strong reluctance of the doctors and ANMs to share their knowledge with the health workers and provide supportive guidance to the

VHWs in treatment of common ailments. The medical and paramedical staff felt their positions of power and influence to be threatened by the lay health workers.

3. The resistance of the doctors and staff of government health institutions to improvement of health of people through low-cost techniques, was another major factor. Their income from treating minor ailments was threatened and hence they tried to influence the community as well as the leaders, against cooperating for the preventive health actions advocated by the VHWs treatment as well as against receiving treatment from them.

4. The community leaders who were automatically nominated by the community to the Health Committee, were the rich and influential persons, *who sought to influence the health system towards more sophisticated curative care for themselves, rather than get involved deeper for better health status and equitable health development of the community. This has been a major hurdle which the project staff have not been able to efficiently overcome, and as a result community participation has been limited to a few supportive actions such as donation of land and payment of honoraria to health workers.*

5. The power structure of the community and hold of the leaders stemmed from the poverty and poor quality of life of the majority. Hence it was their own vested interest to keep the rest of the community poor and backward. This also resulted in lack of cooperation by the leaders to launch community-wide actions for health.

6. Another constraint has been the contined curative bias of the Project staff, inspite of the Project's objectives being preventive health care. Particularly, ever since the allied preventive programmes of sanitation, economic development and improvement of nutrition were abandoned in 1977, the curative bias has been marked and this bias is compounded by the feelings of better recognition in the community achieved by curative services rather than preventive care. The curative bias to some extent is present at all levels, among the VHWs, the ANMs and the physicians.

LEARNINGS FROM THE PROJECT

Since the project went through a series of changes including a major crisis which necessitated a review of the programmes repeatedly, many lessons learnt on the way have helped the evolution of the Project.

1. In the Mandwa Project, Governmeant staff and the project staff, paid similar salaries, have been functioning in a coordinated manner, keeping in view the objectives of health of the people. Most of the Project staff working are average professional and paraprofessional staff recruited by the Foundation and Government. Yet good working conditions, encouragement, appreciation and moral support, in other words good relationship, provided by the Foundation, has succeeded in drawing the best out of them.

2. One of the earliest learnings was that, health is not a priority felt-need of the people. Socioeconomic betterment takes precedence over health and, the process of effectively organizing the community to really plan and participate for their health is a prolonged one which needs committed full time health leaders resident in the villages.

3. In the course of involving the community, utilizing the community leaders for a planned introduction of preventive community-based health services requires intensive efforts for community organization. Otherwise, their participation may get limited to items such as donation of land and infrastructure and undertaking some recurring maintenance costs.

4. The ANMs, who are expected to serve as the first level of referral and to provide supervisory support to the VHWs, however, did not fulfil their roles adequately. Firstly, they were reluctant to share medical knowledge and improve the VHWs skill for curative services which would enhance the VHWs status in the community. Secondly, supervisory abilities were not inculculated during their training in the District Hospitals, as they have been conventionally envisaged as frontline workers in the Primary Health Care delivery system. This aspect needs to be tackled and suitable changes in training and role definition of the ANM need to be made before the VHW system is attempted to be replicated on a larger scale.

In the context, of the Mandwa Project, the Project leaders were able to provide the necessary training and supervision to the VHWs, initially through the Community Organizer and subsequently, through two male Community Supervisors who were suitably trained.

Case Study: VI

A.V.R. FOUNDATION OF AYURVEDA -- A COMPREHENSIVE RURAL HEALTH PROJECT

An essential principle of primary health care is the use of appropriate technology and utilization of effective traditional remedies as part of the overall strategy to provide health for all. The following is an account of community participation in a health project aimed at integration of effective traditional remedies with modern techniques of maternal and child care, immunization and family planning. Further information on the benefits and effectiveness of this model for primary health care is lacking in this project; nevertheless, the process which the Project staff adopted to enlist community participation, by mutual sharing of knowledge of local herbal remedies, appears exciting and relevant. Given the perpetual shortage of drugs in our PHCs and subcentres, and shrinking drug budgets per capita served, the use of effective local remedies for relieving minor ailments can strengthen delivery of primary health care. A much more systematic documentation of the effectiveness of remedies and the impact of the whole process on health of the community is possible in this Project, and needs to be done if it is to serve as a model of integrating traditional and modern systems of medicine for primary health care.

THE COMMUNITY SERVED

The community consists of a population of over two lakhs in Periyanaickampalayam block and adjoining parts of Karamadai block of Coimbatore Taluk of Tamil Nadu.

When the project commenced in 1984, the population covered consisted of twenty-six thousand people in four village panchayats. Of them, one village panchayat was tribal, two villages typically rural, and one was a semi-urbanised village panchayat situated on the outskirts of Coimbatore city with many small industrial units feeding the industrial town of Coimbatore. Subsequently, as the project area was expanded to cover a larger population, approximately the same proportion of tribal, rural and semi-urban populations was retained. The community served was similar to any other rural or tribal area in Tamil Nadu in terms of health and socio-economic status.

THE PROJECT : PHILOSOPHY, BEGINNING AND OBJECTIVES

The rural health project was taken up as a part of building up the Institution of Ayurveda located at Coimbatore. The activities of the Institute include, training of students in Ayurveda, clinical research,activities for propagation of ayurvedic practices for health and disease, and publication of a journal. The objectives can be perceived at two levels. At the institutional level, the objectives of the management in starting the project were : As an extension of the educational process, with the idea of training students in community health aspects of Ayurveda, and to experiment with the possiblity of systematizing the indigenous medical practices prevailing in our villages, and to attempt to integrate Ayurveda in the health care system of the villages. Besides, this project was to provide in the long run, a research base for the Ayurveda Foundation to conduct research on locally available medicinal plants and their uses.

At the Project level, the specific objectives tc be achieved were

(i) To develop an organized programme of Ayurveda in community health and develop a model which could be considered for implementation by Government and other voluntary agencies.

(ii) To contribute to health and development of the community through integration of traditional systems of medicine and modern practice of MCH care and other primary health care practices.

(iii) To specifically develop women as a resource not only for practices of indigenous medicine in the village but also to propagate health practices in the community.

(iv) To develop a community-based centre for training of health workers in ayurveda and indigenous systems of medicine.

The project was taken up with the financial assistance of the Ministry of Health, Government of India, under the Private Voluntary Organizations for Health (PVOH) scheme, in April 1984 and originally scheduled for five years. Prior to the start of the Project, a workshop was convened involving senior community health experts of the country, to review the proposed project and make suitable recommendations. Incorporating the suggested modifications, the project was launched.

PROCESS OF PROJECT IMPLEMENTATION

Initially the project began with the idea of popularizing Ayurvedic and medical health practices based on locally available medicinal plants and materials, with the full participation of the community in the process. With these objectives the project officer, C R Bijoy, along with an Ayurvedic Physician (a lecturer of the Ayurveda Institute) and some additional staff were appointed to commence the process of building up the Project, starting with building up physical facilities (the health units), and popularizing Ayurvedic medicine with the participation of the community. The process began with the establishment of the Rural Health Centre with a resident Ayurvedic physician and two Siddha physicians, at the village, Veerapandi - No. 24, 23 kms from Coimbatore. All staff, whether physician or otherwise, began their work with a dialogue with the community leaders, first of all to secure a place to locate the health units from the community's resources, secondly, to understand the existing disease pattern in the community, and thirdly, to study the already existing indigenous medical practices as practiced by voluntary informal practitioners who have some knowledge of medicinal values of locally available plants and who treat illnesses. The last group especially, included many women in most of the villages.

Physical facilities for four health units were established on the understanding that the project would not bear expenses for them, and that land, building, etc should come forth from the community. On this basis health units were established at Nanjundapuram, Narasimhanaigam-Palayam and Thekampatti villages.

The project leaders and staff began the work with the idea of teaching systematic Ayurvedic practices to locally developed Health Promoters and existing Siddha physicians in the villages. They were to be taught the principles of Ayurveda and the medicinal properties of locally available plants. To their

surprise, the project workers in the course of dialogue found that, first of all, the majority of the indigenous medical services were being rendered on voluntary basis by women and some other volunteers who had gained knowledge of medicinal plants and these persons treated common ailments among their neighbours and neighbouring villages for relief of suffering and not as a livelihood. Secondly, they found there was already a rich body of knowledge of medicinal properties of plants and preparation of medicines by simple methods. The actual problem was that this knowledge was fragmentary and each practitioner was conversant with a few medicines for a few conditions, while another was effective in treating certain other types of ailments.

These findings resulted in a change of method of operation of the project. Thereby, the physician now assumed the role of organizer of meetings of locally practicing women and Siddha physicians, guiding informal dialogue between them to bring out the merits of each participant's knowledge and bringing about consensus on effective treatment of certain conditions. The consensus reached at such meeting was verified by the Ayurveda physician as to how far the medicines agreed upon by the group was in tune with established Ayurvedic theory.

The project officer, social workers and any other staff assigned to the team, chiefly concentrated on identifying who were these people who treated common ailments in the community, who were the motivated active women in the community who could be trained with knowledge of indigenous medicines as emerged from the dialogues.

The women identified from the community and trained as Health Promoters were paid a monthly honorarium of Rs.500/- which was later reduced to Rs.250/-. They were trained to organize women for better awareness and action for socio-economic development, health promotion and use of indigenous medicine, health promotion through immunization and MCH. They were also trained to conduct antenatal checkups, and of late, they were also trained to conduct deliveries in the villages. The four Rural Health Units, each with a resident Ayurvedic physician and an ANM (Auxiliary nurse cum mid-wife) served as the first level of referral for the health promoters and other traditional practitioners in the village, for treatment of diseases and maternal and child health (complicated cases). The Health unit also served as a camp venue for the immunization camps which are organized from time to time by the staff and the Health Promoters' efforts. The staff of Periyanaickampalayam PHC administer immunizations at these camps.

After the Health units were established , the project has also been serving as a training ground, where innumerable voluntary organizations across the country send their social health workers for demonstration-cum-training in initiating the process of nurturing indigenous medicine in their respective project areas.

ACTIVITIES

The activities can be classified as follows :

(A) Promotion of Indigenous Medical Practices :

(i) The Rural Health Centre at Veerapandi - No. 24, functions as a base hospital for the project area with a resident physician, students from the Ayurveda Institute posted for training, and other supportive staff. The preparation of Ayurvedic medicines for patients or for the health promoters' use is carried out at the Centre itself with simple methods. Medicines prepared here are dispensed for the use of the health workers in the two blocks. It also serves as a referral hospital for complicated cases, cases not responding to the medicines given in the village, and complicated ante-natal cases referred by the health promoters and other local practitioners.

(ii) At the Rural Health Units, where a resident Ayurvedic Physician, an ANM and one or two supportive staff are posted, Ayurvedic curative, and MCH services are provided. In addition, the staff also go out into the community to organize the community youth, women, and similar active groups for creation of awareness and action for such diverse activities, as protesting for the rights of the tribals over forests, creation of herbal gardens to grow medicinal plants, publication of a journal by the local medical women-"Sarani", etc.

(iii) School health programme is carried out in the project area by the physicians and Health promoters. Minimum three check-ups per year are carried out for school children. During this check-up, health education sessions are carried out for the children; they are taught to have a respect for indigenous medicine, and use it themselves for simple ailments including injuries which school children are prone to and therefore can practice the knowledge given to them. School children are involved to spread awareness and popularity of Ayurvedic medicines in the community; videos, slides, flip charts, etc., are used.

(iv) The Health Promoter with the assistance of locally practicing village women, registers pregnant women for antenatal checkup, ensures tetanus-toxoid immunization of pregnant women, distributes iron and folic acid tablets for prevention of anemia, and in addition provides certain ayurvedic medicines which are helpful for maintaining good maternal and child health and promoting safe delivery and peuperium. She treats simple ailments with locally available plants or with medicines from the Rural Health Centre. She also assists the Project staff to organize meetings of indigenous practitioners and enlists their help for her work. One Health Promoter is responsible for a population of 5000 - 10,000 depending upon accessibility of the villages and availability of a local suitable person.

(v) The Health Units assisted by the Health Promoters organize immunization camps by mobilizing eligible children in the area and getting the PHC staff to provide immunization services to ensure maximum coverage.

(vi) Training programmes are conducted on a informal basis at the Project for health workers and social workers of other voluntary organizations in the country on how to nurture indigenous practice of medicine in their respective areas.

(vii) Motivation of eligible persons for family planning is carried out at all levels.

(V) ORGANIZATIONAL STRUCTURE AND LEADERSHIP

(A) Leadership :

The Comprehensive Rural Health Project functions within broad guidelines laid down by Dr P R Krishnakumar who is the Executive Chairman of the A.V.R foundation. Leadership to the

project is provided by the Project Officer, C R Bijoy, who organizes the activities and directs the project.

(B) Organizational Structure :

An Ayurvedic physician, two Siddha physicians and other supportive staff manning the Rural Health Centre; the four ayurvedic physicians residing at the four health units, four ANMs

and few other supportive staff, make up the formally appointed staff of the rural health project. From the community there are about forty health promoters for a population of two lakhs who draw an honorarium of Rs.250/- per month, and they comprise the grass root level staff. Each health promoter covers five thousand to ten thousand population. The organization of the project functions parallel with the conventional Government health services in the area which has the usual staff pattern. Totally 69 staff including the project officer are employed under the Project including the health promoters.

PROCESS OF COMMUNITY PARTICIPATION

(A) Health :

(i) The community in each of the villages of the entire project area, through a process of dialogue between the traditional practitioners, have themselves evolved the ayurvedic component of the integrated primary health care programme that is functioning today in the area. With some guidance from the formally trained Ayurveda and Siddha physicians of the A V R Foundation to promote sound practices and give up ineffective practices, some guidance of the physicians to evolve better methods of preparation of medicines, and some guidance to add to their existing knowledge of locally available medicinal plants,there has emerged and effective system of Ayurveda combined with modern preventive practices such as immunization and MCH, which is acceptable to the people, affordable (because of being based on locally available herbs and plants), and accessible. Primary Health Care is available through local indigenous practitioners who are also oriented to modern preventive health practices.

(ii) Health Promoters selected from the community and working in the community are undertaking the responsibilities of MCH, treatment of minor ailments, motivation for family planning and other primary health care activities.

(B) Socio-Economic Betterment :

Women's clubs, youth clubs and other such organizations promoted and fostered by the project, today, are tackling many socio-economic ills, including

deforestation by forest smugglers and forest contractors; women's oppression, and many other issues. The Women's clubs in the project area jointly publish a journal in Tamil "Sarani" through which issues of deforestation and consequent lack of rainfall, and other environmental and social issues relating to the poor and the tribals are projected. This journal is widely circulated far beyond the project area

The change envisaged for the community has been chiefly that of an improved health status through integration of the traditional systems of medicine, Ayurvedic and Siddha in primary health care and to create awareness and action-taking among people for health and socio-economic betterment. Being an organization committed to the traditional systems of medicine which are rooted in the people, the change process employed by the project leadership, began work with the community, initially to accept the integrated primary health care. But subsequently the project staff solicited community participation to actively contribute to the knowledge on which, finally, the primary health care practices in the area would be based. This methodology of bringing out the people's knowledge to implement integrated primary health care, facilitated a community participative process of social, economic and health status improvement, based on the activities of women's clubs, youth clubs and the local informal village practitioners which were stimulated by the Project.

While the traditional medicine already prevailing in the villages has been successfully integrated with modern maternal and child health, information on the impact of such integration, is not really available. The AVR Foundation health infrastructure functions relatively independently of the Government Health Service in the area, which is, presumably, also utilized by the community. Hence, in the absence of information from an evaluation survey, the results in terms of impact, is difficult to assess.

Due to the supportive activities for MCH by the project staff, there has been improved coverage of immunization, but in terms of morbidity, relief of sickness, child survival and other health indicators, impact could only be assessed by longitudinal data maintained on the community served.

VIII. COLLABORATION AND CONFLICTS

(A) Relationship with the Governmental agencies in the area :

The Project centering around the Rural Health Centre and its four Health Units has been established, parallel to the government health establishment (Primary Health Centre, sub- centres and the related staff and Programmes). However, the area being hilly with certain parts being inaccessible by road, the project leaders selected certain under-served areas which were remote from the Primary Health Centre for implementation of the project. As such there was very little contact between the Project staff and the Government health staff. However, whenever the project staff received information through various means that the Primary Health Centre, Periyanaickampalayam, was due to conduct immunization camp in a particular area, the project staff of the area worked intensively to mobilize most of the children of the area to attend the camp.

The attempt of the project staff leaders to secure a regular supply of vaccines from the District Health Officer and the Medical Officer of the PHC initially failed to draw a cooperative response. Subsequently, after the government health staff

realized the collaborative nature of the project work and its contribution to improve the immunization coverage, and in response to the letter issued by the Ministry of Health, Government of India for supply of vaccines, the District Health Officer has began to supply vaccines including tetanus toxoid for pregnant mothers, and iron and folic acid tablets to the project. In turn, the project staff are requested for their cooperation and active involvement to motivate eligible couples for family planning. With increasing pressure on the PHCs from the State and national authorities for improvement of immunization coverage, the government health staff in collaboration with the project staff conduct regular immunization camps in the area, wherein the project staff assume the responsibilities of mobilizing the children for high coverage, and PHC staff come to the camp and provide the services.

Considering the reporting, by the project staff to the PHC and the district health office on the National Programmes for inclusion in the overall PHC data of PHC Periyanaickampalayam, the project does not report on any of its activities such as disease or health statistics, progress in the maternal and child health activities, etc. Reporting is only for the purpose of giving an account of consumption and requirement of vaccines and iron and folic acid tablets provided by the DHO.

(B) Relationship with other voluntary agencies :

(i) Several Voluntary agencies across the country are sending their workers for training in the process of nurturing indigenous systems of medicine.

(ii) Before the project was even begun, several voluntary agencies were invited to the workshop to advise the AVR Foundation on the Project.

(C) Relationship with the community :

Being a project based on community participation and consensus at every stage, from acquiring the physical facilities to commencing activities, and to evolving the knowledge on which the primary health care could be based, there was very little conflict with the community.

X. FINANCIAL RESOURCES

The project has been funded by the Ministry of Health, Government of India under the Private Voluntary Organisations for Health (PVOH) Scheme to the extent of 75%, and 25% was to be contributed by the Foundation over a period of five years. It was envisaged that Rs.60 lakhs would be released in instalments, keeping in view the matching 25% to be raised by the Foundation for the Project. Owing to lack of adequate fund contribution by the Foundation, the expenditure has been Rupees forty lakhs over a period of five years or an annual budget of approximately eight lakhs. Bulk of the budget is spent on staff salaries and honoraria to the Health Promoters. Building for Health Units are contributed by the Community.

Case Study: VII

PRIMARY HEALTH CARE PROGRAMME FOR TIBETAN REFUGEE SETTLEMENTS

This is an account of the process of building up a health care system for Tibetan refugees, by the Tibetan Administration in Exile based at Dharamsala in Himachal Pradesh. Following the Chinese occupation of Tibet, there was a massive exodus of Tibetans in 1952 to the neighbouring countries of India, Nepal and Bhutan to escape the oppression of the Chinese government. A permanent solution to resolve their refugee status and to enable them to return to their homeland, continues to elude them. Under the circumstances, their religious head, the Dalai Lama initiated a health programme for the Tibetan refugee settlements, scattered far and wide, to provide some basic health care with available resources from foreign donor agencies and the Tibetan community. The following is an account of the evolving Tibetan health services in India.

THE COMMUNITY SERVED

The community consists of about 1,10,000 Tibetan refugees in exile, who have fled to India and Nepal in 1952 from Tibet following the Chinese occupation of Tibet. Majority of the Tibetans, about 85,000, are settled in India, mostly in the hilly regions of Northern India, and the remaining distributed in the southern, central and eastern parts of the country. Owing to their refugee status, the Tibetans were distributed in settlements across the country, which were expected to be temporary camps. These temporary camps, with makeshift constructions and almost no civic planning, have been their settlements for almost 30 years. Initially, available international aid was given for food supplies and camp construction by the UN High Commission for Refugees. Subsequently, with no resources or citizenship in the country of their settlement, living in unhygienic, unplanned shelters, faced with poverty and heavy labour to earn a petty livelihood, faced with the extreme change of climate, from the extreme cold of Tibet to extreme heat, the mortality was very high in the early years of their settlement. Both adult and child mortality was high. Added to this they were faced with sudden exposure to tropical diseases like malaria, and especially, certain diseases from which their cloistered civilization was completely protected in past centuries, and they became a highly susceptible population to these diseases. Tuberculosis is among the major causes of illness and death.

Totally, there are about 150 Tibetan settlements in India and a few in Nepal. About 85,000 refugees are settled in India and the rest in Nepal. Of the Indian settlements, about half are major and minor agricultural settlements, and about 10 are handicraft centres. Buddhism is the only religion practiced. The Buddhist philosophy of contentment in any situation has helped them to adapt to the extremely difficult situation. An agricultural base, supplemented by rug and carpet weaving, making and selling sweaters, sustains the Tibetans economically.

Added to the problems arising out of their refugee status, poor sanitation and overcrowding have added to morbidity. The most important causes of morbidity

have been fever, malaria, tuberculosis, diarrhoea, skin diseases and infectious hepatitis, in that order. Problems of heart disease, glaucoma, hypertension and chronic arthritis that characterize an aging population are also high. (Aged population is a prominent characteristic of the Tibetan refugee population for various ill-understood reasons). However, these problems are overshadowed by these above mentioned emergent communicable diseases.

The incidence of infectious tuberculosis among them is atleast two and half times its incidence in Indian population. Incidence and severity of the disease among adolescents and young adults is particularly high.

In keeping with their semi-nomadic culture and existence in Tibet, they migrate annually for about 3-4 months, often rendering the long duration of anti - TB treatment, difficult to administer. Thus drug resistant disease is common among them.

Since they are refugees, in administrative terms, they are not eligible to be covered for the public health programmes and primary health care by the government health services. This made it necessary for the Tibetan Administration to begin from scratch to develop their own health services, and to solve problems on the way, as and when the health service developed.

THE PROJECT : BEGINNING AND OBJECTIVES

Given these extreme circumstances, during the first two decades, the priority of the Administration-in-Exile was to ensure bare survival, to co-ordinate and build-up living quar ters, and to develop agricultural and other means of livelihood on land donated to them by the host Government of India. In 1984, when some degree of stability was achieved, health and mortality problems began to be perceived as a major hurdle in achieving a

quality of life. Tuberculosis, malaria and diarrhoeal diseases were rampant; haphazard treatment and failure of TB treatment showed up; large number of adolescents and young adults were claimed by this disease; malnutrition, diarrhoea, poor maternal health, maternal and child mortality, were prominent. Against this background, the Administration-in-Exile, under the patronage of the Dalai Lama, started the Primary Health Care Programme with the following objectives :

a) To care for the health needs of the Tibetans in refugee settlements in India, Nepal and Bhutan through a comprehensive Primary Health Care (PHC) programme and thus contribute to the Government of India's National Health Programme, and eventually to achieve Health For All Tibetans in exile by 2000 AD.

b) To adapt the general principles of Primary Health Care, its strategies and activities to the actual circumstances, keeping in view their refugee status.

c) More specific objectives related to mobilizing resources from international and national agencies, specific goals in planning, implementation and evaluation of the programme are set from year to year.

The priorities of the health programme are in consonance with the urgent needs and are as follows :

- Control of Tuberculosis
- Maternal and Child health
- Training of personnel and Human Resource Development for health care
- Health education
- Essential drugs
- Integration with Tibetan Medicine

ACTIVITIES

The activities are being carried out at two levels in most of the regions. A Referral hospital established in each of the ten regions serves a population ranging from about 5,000 to 15,000, living in many scattered settlements in the respective regions. There are several referral hospitals - the Delek Hospital at Dharmasala, Tibetan Homes Foundation Hospital at Musoorie, the Chandragiri Health Centre at Chandragiri in Eastern India; the Mainpat Health Centre and the Bhandara Health Centre in Central India, the Majnu-ka-Tilla Health Centre in Delhi, the Deoguling Hospital at Mundgod, and three other hospitals in the South. At the Health Centre level, almost one in each major settlement, primary health care is delivered mostly through Community Health Workers, nurses or other paramedical workers, serving populations ranging from 300 - 5000. There are 45 health centres (including three centres in Nepal).

A. Activities at the Health Centre Level

a) Out-patient services - mostly free of cost owing to poverty.

b) TB Control Programme : Under the TB control programme, identification of suspect cases, referral to nearby Government health facilities or the Tibetan refugee hospital, ensuring regularity of treatment including supervised drug administration to each patient and record maintenance; are the activities carried out. Home visiting both for identification of cases, treatment, and retrieval of treatment defaulters, is a part of the activity.

c) Maternal care - Antenatal care including immunization, intranatal, post natal care.

d) Child care - growth monitoring and immunization.

e) Health and nutrition education.

f) Sanitation Campaign.

B. At the Referral Hospital Level

At this level at least one doctor, paramedical staff and supportive staff to run the hospital are available. At this level, in addition to the Primary Health care activities listed above, other activities are

a. Out-patient Service

b. In-patient Service

c. Eye Care

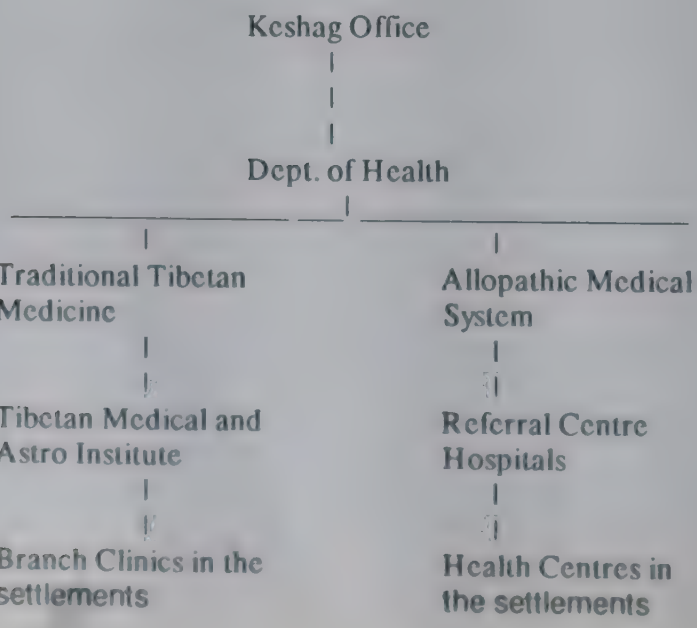
d. TB control Programme on a referral level, i.e laboratory services for diagnosis, treatment of drug failures etc.

e. Health Workers Training Programme to train health workers for the settlements.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The leadership to the Tibetan Health Programme, as in the case of all Tibetan refugee activities and programmes, is provided by His Holiness, the Dalai Lama who is regarded by all as the spiritual leader, and is by and large, the political leader, too. His leadership and inspiration has succeeded in maintaining the separate cultural and nationalist identity of the Tibetans, in the face of severe survival problems. Even many of the growing second generation, born and brought up in a culture alien to theirs, are committed to the Tibetan identity. In spite of low salaries being paid to doctors, paramedical staff and other workers, who can easily get better paid jobs elsewhere, the spiritual leadership of Dalai Lama attracts them to serve their own people.

The Dalai Lama guides the apex policy-making body, the Kashag Office, consisting of respected monks and experienced administrators. The organizational structure is as follows :



The basic staff available at the health centres consists mostly of Community Health Workers, in addition to a nurse or pharmacist, and one or two other supportive staff.

At the hospital level, except in the case of Delek hospital at Dharmasala, the other hospital have an allopathic doctor, mostly an Indian national; in some hospitals a doctor trained in Tibetan medicine is also available. Many hospitals, and most of the larger health centres, are headed by lay administrators trained in health care and health issues at the Delek hospital. At the Delek hospital, specialist doctors and larger number of staff are available. The health administration of each health centre or hospital, functions directly under the control of the Representative of the Dalai Lama, posted to the settlement (mostly a Buddhist monk), who also administers the socio-economic and housing programmes of the settlement.

PROCESS OF COMMUNITY PARTICIPATION

The process of Community Participation in the case of Tibetan Health Programme, has to be viewed in the peculiar context of high degree of feeling of ethnic, racial, religious and cultural identity among the Tibetans, fostered and led by the spiritual head, who is also the political head, the Dalai Lama. Together with their continuing refugee status, this has led to strong sense of "Community" with a sense of oneness, rather than the fragmented multiple lines of division seen in the villages and towns of India. Thus most of the community organization, in a sense, already exists, among these Tibetan settlements, in their refugee status. This is reinforced by the inspiration of the Dalai Lama, and the Representative of the Dalai Lama who leads the community and coordinates most of the developmental, survival and health activities done on a community basis at each settlement. In the Health Programme the people participate as follows :

(i) Most salaried Tibetans pay 2% of their salaries voluntarily to the Tibetan administration i.e the Kashag office and approximately 2% of the health budget is met from this source.

(ii) Every year, contributions are made to the Central Tibetan government and to the Representative at the settlement through cash and kind by the population. Contributions by the community account for 3% of the health budget.

(iii) Many young Tibetans have come forward to be trained in health as community health workers, pharmacists and nurses and continue to work with their community at relatively low salaries and in trying conditions, rather than go into lucrative jobs. As a result, the expenditure on staff salaries is less than 1% of the total health budget.

(iv) With increasing health education, in many Tibetan settlements, the community has undertaken sanitation work, provision of safe drinking water, economic and social support to families with TB patients.

(v) Voluntary contributions both in case and in the form of labour for construction of hospitals and health centres in various areas, have been made. For instance, during the construction of the branch of the Tibetan Medical Institute and Research Centre Project at Bylakuppe in Karnataka State, the local settle-

ment provided substantial voluntary and low paid labour, as well as financial contributions.

(vi) With increasing health education, the community participates actively in availing and mobilizing other fellow Tibetans for the maternal and child health, immunization, TB control and other programmes.

COLLABORATION AND CONFLICTS

The Tibetan refugees settled in India with the permission of the host Government of India and the concerned State Governments, wherever the settlement was created. As such, the role of the host government has been mostly facilitatory. However, owing to the ambiguous status of the refugees, "Coverage" in the sense of primary health care was not provided by the local health services.

The Tibetan administration has been assisted with financial grants from the Government of India and the State governments, wherever the health centres and hospitals are located. In addition, grants of food stuff are given to support construction activity, e.g, bulgar wheat and soya oil grant given by the Special Deputy Commissioner of Mysore towards supporting Tibetan labour involved in construction of the Bylakuppe Medical Centre.

Tibetan patients attending the local government hospitals and PHCs are treated on par with local patients.

Collaboration exists between the District TB Centres and the settlements for TB control. Referral hospitals for TB in the country and the National Tuberculosis Institute also provide services as and when needed.

Voluntary agencies in the country, such as Christian Medical College, Vellore, Voluntary Health Association of India, and several others have provided and continue to provide valuable services like training community health workers, providing health education materials, consultancy services, etc.

Generally, there has been no conflict with the government, voluntary agencies, or the community.

RESULTS

The process has been one of slowly developing the health system from scratch. Community Health Workers are being posted to the dispensaries as and when they are trained. So far 27 Community Health Workers have been posted. Large number of posts are still vacant and about 46% of the Tibetan population is yet to be covered by the Tibetan Health Service. Currently, the situation is one of mustering all resources towards expanding the services to cover the population with any paramedical staff and resource available, to deliver emergent needs like TB control programme and immediate treatment of illness. Where the PHC programme has been going on for some time, preventive programmes are being added. Monitoring of results and evaluation, are not yet a part of the programme. However, given the staff set-up, treatment of TB cases and other needs are being

carried out remarkably well. Results in terms of impact are not available at the present time.

FINANCIAL RESOURCES AND SPENDING

The annual health budget has been of the order of 28-35 lakhs of rupees in recent years. Sudden changes from year to year are evident due to fluctuations in donations from foreign agencies which form the chief source of income. About 2% of the total health budget is raised from the contributions of the staff of the Department of Health. One fifth of the budget, both receipts and expenditure, is accounted for by the TB control programme, the funds being received chiefly by donations, and spent towards drugs. Staff salaries consume less than 1% of the health budget. Contributions by the community itself accounts for about 3% of the budget.

Case Study: VIII

VIVEKANANDA GIRIJANA KALYANA KENDRA -- INTEGRATED TRIBAL DEVELOPMENT AND HEALTH PROJECT

This is an account of a tribal health project which grew into an integrated health and development project in B.R. Hills and surrounding forested areas of Mysore district in Karnataka.

In 1979, Dr H.Sudarshan, a young medical graduate inspired by the action philosophy of Swami Vivekananda, came to B.R. Hills in his quest for an ideal place to serve suffering humanity. He found that in these picturesque hills, lives an isolated marginalised tribe of people called Soligas. Deprived of their traditional forest resource base through forest laws, laws providing for the protection of Wild Life, the greed of forest contractors and colluding forest officials, prevented from utilizing their traditional sources of nutrition nd shelter in the forest, the Soligas had been reduced to a semi-starved, extremely poor community exploited, bullied and driven from place to place by officials and armed forest contractors. Added to the remoteness of their habitation their own peculiar culture and fear of civilized man, their resulting isolation from all modern civilization including health services, was similar to that of hill tribes over most of the country. Their extreme poverty, malnutrition and high morbidity prompted Dr Sudan to settle down in the area to provide medical care to the tribals. The Project has grown from a small hut providing basic medical services to an integrated tribal development centre, the Vivekanada Girijana Kalyana Kendra, providing guidance and organizational support for the development of over 20,000 Soligas living in these areas. The following provides an account of the leadership provided by the Kendra in the health, socio-economic development and the human resource development of the tribal community.

THE COMMUNITY SERVED

The tribal community served by the project consists of a population of approximately twenty thousands, distributed over a wide area of sixty kms radius from the centre,living in small settlements, situated in the dense forests of B.R. Hills, Yellandur, Kollegal, Chamrajanagar and Satyamangala Taluks of Karnataka and adjoining Tamil Nadu. These people lived on the minor forest produce and the produce of shifting cultivation in clear areas between trees, clearing the grass and weeds by burning them. The chief crop was ragi. Forest produce included wild fruits, number of small game and the green leafy vegetables of several species. Their life style is essentially community based, and the produce gathered is shared equally among members of the settlement as well as any guest (wandering tribals) from other settlements. With the advent of forest conservation and declaration of B.R. Hills as a reserve forest, ban on hunting as well as gathering minor forest produce, their entire source of livelihood was taken away, and they lived in a state of extreme poverty, undernutrition and exploitation, continually chased and harassed by the various authorities. Thus their living conditions had drastically deteriorated in recent times, rendering their age-old skills for living in the forests obsolete, with no notion of the civilized skills to make a living in "Civilized Society".

They speak a dialect of Kannada language and use the barter system of exchange. Almost hundred percent were illiterate at the time of starting the project and there was no notion of fixed property since they were nomadic. Prevalence of malnutrition among children was of the order of about 50%, infant mortality was about 150 per 1000 live births. Diarhhoeal disease was rampant among the community. Most of the tribal people were almost untouched by civilization; no health worker had made contact with them previously, and these people shied away from any contact with any outsider. When Dr. Sudarshan first reached B.R. Hills, it took almost one year for him to gain the confidence of the people, even to be able to speak to them.

The tribals had to travel a distance of about 20 or even 50 kms to reach the nearest health centre.

THE PROJECT : PHILOSOPHY BEGINNING AND OBJECTIVES

The project was started by a one individual with the sole aim of providing medical care to the tribals of B.R. Hills. At the same time, in line with the philosophy of socialistic way of life, Dr. Sudarshan tried to understand the felt needs of the tribal people. He soon found that health was far from their minds and the most acute problems were poverty and lack of means of livelihood.

This realization paved the way for a complete change in the objectives of the Vivekananda Girijana Kalyana Kendra, which shifted from mere medical care to integrated tribal development work. The objectives of the Project are as follows :

1. To realise the vision of a self-reliant, united and progressive Soliga tribal community.

2. To identify the latent human potential of the Soligas through motivation, education and training, and through building up their self confidence in developing themselves. In this process to encourage them to retain their culture , and at the same time adjust to the changing circumstances.

3. To build up people's organizations such as Abhivrudhi sanghas, a forum to take up the fight for welfare, justice and fundamental rights.

NATURE OF THE PROJECT AND SCOPE OF ACTIVITIES

The project covers the areas of health, education, adult education, community organization, cottage industry and vocational training, agriculture, housing and co-operatives.

All activities in the project since inception, have been oriented to the felt needs of the people, as and when they emerged as felt needs during participative discussion between the Kendra missionaries and the community. The attitude of the Kendra has been one of teaching and learning at the same time, and not one of doling out health or welfare. Health care, specifically, curative medical care, has been the chief entry point of the Kendra into the Soliga community and it was a hard struggle to gain acceptance. Some dramatic cures gained their

confidence. Subsequently, the emphasis has been on preventive community health, the objective being to educate and gain the local people's participation in the health activities, by creating awareness of health needs through health education.

A. Health Activities

(i) Medical Care :

A well equipped hospital with ten beds, an outpatient clinic, X-ray clinic and laboratory, serves as a base hospital for the whole area. About 13,000 out-patients and about 200 inpatients are treated every year. The laboratory has facilities for examining blood, urine, stools and sputum. In addition, calorimetry and electrophoresis, are carried out to identify sickle cell anemia, which is a genetic disease prevalent among these people. Screening and X-ray photography are also carried out.

A systematic screening programme has been established for all tribals, so as to identify, follow-up and treat sickle cell anemia cases.

Mobile medical services are being provided through periodic visits in mobile medical vans to the distant hamlets, some of which are 80 kms from the Centre.

(ii) Community Health Activities :

(a) Activities of the Village Health Workers :

Thirty village health workers selected by the village people have been trained, for the 90 tribal hamlets in three taluks. After initial training at the hospital they attend ongoing training for two days a month at the Kendra. Community health problems are handled by them through health education, first aid, safe delivery practices, treatment of minor ailments, and referral. They are also encouraged to continue to use their traditional herbal medicines. The village health workers thus live in the community, and take care of the people , without feeling that they are compelled to use an entirely new system of healing, namely, allopathy, or, that their traditional system of healing is being put down by the educated staff of the Kendra.

(b) Training of Traditional Birth Attendants :

The dais who live in the community are brought to the Centre for training in antenatal care, immunization, intranatal care, care of new born, post natal care and health education of mother and child. While dais are trained in all these aspects they are also encouraged to use their traditional skills to deliver quite complicated cases. The additional training input is to maintain hygiene during labour, and hygienic cord-cutting practice. They are allowed to maintain the custom of delivering the mother in sitting posture which results in easier and uncomplicated delivery.

(c) Immunization Programmes :

Most of the tribal children are immunized against diptheria, pertussis, tetanus, poliomyelitis and tuberculosis.

(d) Health Education :

Health education is carried out by doctors, village health workers and trained school teachers with the help of flash cards, puppet shows, songs and skits. The programme has shown results in terms of community participation and action, such as cleaning drinking water ponds and streams. Oral rehydration campaign has dramatically reduced diarhhoeal deaths.

(e) Traditional Herbal Medicine :

The Kendra has launched a project to scientifically study the herbs used traditionally, in the spirit of mutual learning, community participation and involvement. The health staff of the

base hospital are also encouraged to use the traditional herbal remedies being used by village health workers and dais.

(f) Leprosy Eradication Project :

The Leprosy Eradication Programme has been taken up in Yellandur taluk. The unit consists of one Medical Officer, one

administrator-cum-senior paramedical worker, three paramedical workers, one smear technician and one helper with appropriate training. The strategy consists of the Survey, Education and Treatment (S.E.T) programme, as laid down in the National Leprosy Eradication Programme. The Leprosy clinic-cum-laboratory and Physiotherapy unit functions at a building in Yellandur taluk donated by a local person. Treatment and follow-up of cases are being carried out as per the National Leprosy Eradication Programme guidelines. The survey was combined with health education in order to secure maximum coverage. A rehabilitation unit in sewing and candlemaking has been opened for rehabilitation and livelihood of leprosy cases and cured cases.

(g) The Anganavadis, for the tribals, under the Integrated Child Development Scheme, are managed by the Kendra, one of them being located at the headquarters. A nutritious mid-day meal is provided to all underfive, and pregnant and lactating mothers. Health monitoring of underfives and health education of mothers on nutrition, personal hygiene, kitchen gardening, cooking, etc., are carried out at the Anganavadis.

B. Medical Education

House-surgeons training at the base hospital has been recognized by the Director of Medical Education in Karnataka as an institution for training in rural health under the ROME scheme. Two to four house surgeons are posted for training and they take part in the health and training programmes.

C. Education

(a) A tribal residential school consisting of pre-nursery, primary, middle and high school, has been started by the Kendra at B.R. Hills. It is being run with government funds. Primary and middle schools are also opened at three villages. The school children are taught all the formal subjects, and in addition they are taught regarding community health, leadership and group work for community

development and self-reliance, arts, handicrafts and puppetry, environmental education and other social matters.

(b) Adult education concentrates on social awareness and social responsibilities including health. Functional literacy is the major focus rather than traditional teaching of alphabets etc.

(c) An important aspect of the education being imparted at the school is to teach and encourage the students to develop the skills required for a living in the forest as well as agricultural way of life. Thus as a part of their education the students go to the forest to collect firewood, and to assist in vegetable gardening, for the community kitchen; they are taught to recognize useful plants, trees and medicinal herbs, poisonous and non-poisonous snakes etc. The overall objective is to ensure that the educational process does not alienate then from their people and culture. Elementary teaching material has been developed and written in the Soliga dialect.

(d) Students are imparted environmental education. Vocational training is a part of the education, so that by the time a student completes Class X, he is proficient in atleast one trade to earn his livelihood.

(e) As a part of the Kendra's commitment to a Relevant System of Education for Tribal People, seminars and symposia are hosted for teachers and social workers working with tribal children in other parts of the country.

D. Community Organization

Social workers have gone to the remote hamlets, and organized the communities into democratic Sanghas. They have developed leaders in each community to lead the Sanghas. These Sanghas are now geared to interact freely with government officials and their authorities to solve their problems - socioeconomic, health and other problems, in the spirit of self- reliance. The detailed functioning of these community organizations is described under Section V on Process of Community Participation.

E. Cottage industries and vocational training

The Kendra training centre at the headquarters imparts training to women, men and school drop-outs in the various cottage industriesof weaving, agarbatti making, coir-rope making, bakery, tailoring and knitting, handicrafts, bee-keeping and other skills. A co-operative society was established for the marketing of products. The functionary incharge of the vocational training centre, assisted by trained assistants, provides follow-up advice and support to start cottage industry units in distant hamlets. Also, continued technical advice, and problem-solving efforts are provided by the Kendra.

F.AgriculturalLandRestoration

All alienated land was restored as also the right to shifting cultivation which is carried out without damage to forests. Together with this, promotion of better agricultural practices, seeds and sapling distribution under the tree patta scheme, promotion of dairy farming, were initiated and now these activities are being organized by the tribals themselves.

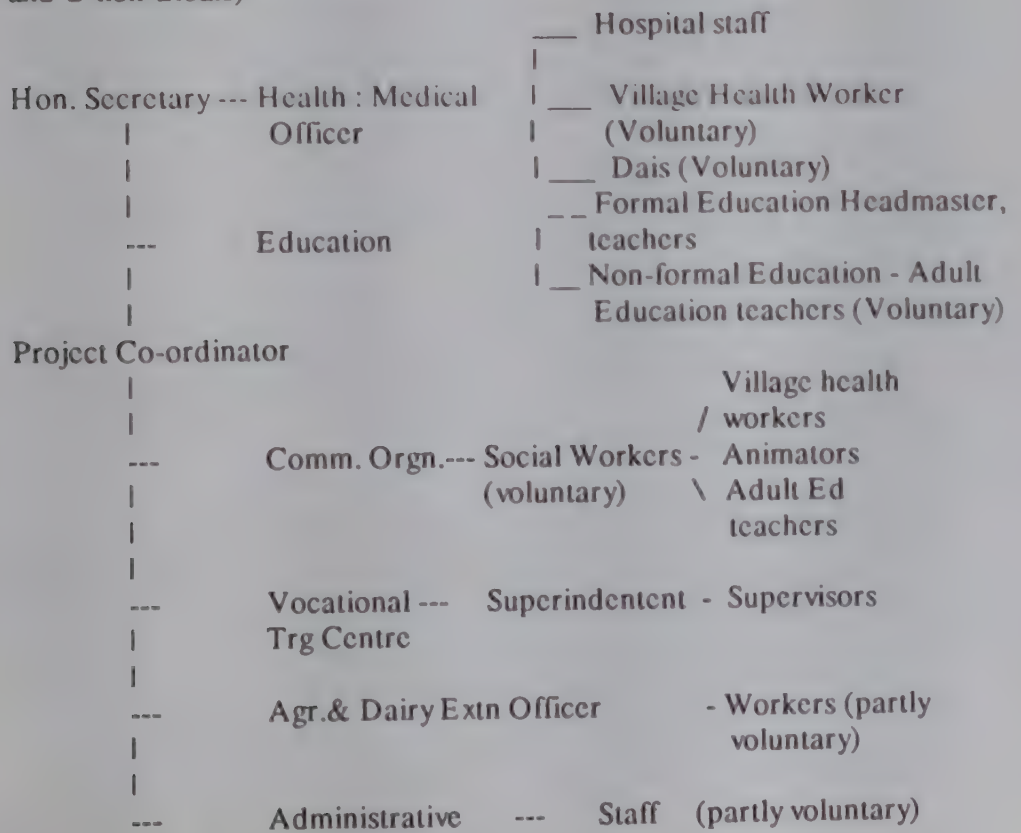
G. Housing and Co-operatives

Liaison work is done with the forest department and other departments to get low cost houses built for the tribals, with the participation of the community. The Kendra was responsible for bringing the institution of Tribal Co-operatives into existence in this region. As a result, the minor forest produce such as honey, soapnuts, etc., which previously was extorted from the Soligas at a throwaway price or no price at all, by the forest contractors and civilians of the plains, is now packed and marketed at reasonable price and has resulted in improving the income of the tribals.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The project has a formally functioning staff of thirty individuals, functioning under the direction of the Governing body consisting of eleven members. Nine members are tribal leaders and two are from among the original project leaders. However, much of the work and labour towards maintenance of the project is provided voluntarily, eg. growing vegetables for the community kitchen, firewood collection, odd maintenance jobs - repair of roofs, etc., which is accomplished by the informal participation of the school students and the community.

Structure of the Organization



The leadership is being provided at three levels. At the top level, Dr. Sudarshan has provided the overall leadership and vision to the Project. In addition to planning and participation in the health activities, he used to lead the activities on almost all fronts in the early years of the project - whether it was liaison or negotiating with the forest department, education department, health department etc. Subsequently Mr. Jayadeva and Mr. Somasundaram have taken over some of these functions.

At the middle level, the two social workers have taken over the responsibility of motivating and organizing local village communities into Abhivruddhi Sanghas, and developing the local leaders, who in turn, gradually take the initiative to work for socioeconomic development.

At the village hamlet level, the youth and community leaders who form the Soliga Abhivruddha Sanghas, lead and guide the community for the various progressive activities such as, ensuring attendance at school by school children, enrolling adults for adult education, liaison with forest officials for land ownership and forest produce, etc.

Today, the top level leadership consists of the members of the Governing Body at the Kendra level. The non-tribal original leaders of the project, Dr. H. Sudarshan and his colleagues envisage that, within a period of about three to five years hence, they would be able to withdraw from the project completely, and hand over leadership for tribal development entirely to the tribals.

PROCESS OF COMMUNITY PARTICIPATION

(i) Health :

To promote primary health care in the village the chief thrust was on health education and creation of awareness regarding disease prevention and health promotion. This led to substantial participation by the community in primary health care as follows :

(a) The community in ninety hamlets of three taluks selected persons from their village to be trained as village health workers. These health workers live in the community and deliver Primary Health Care through health education, first aid, treatment of minor ailments, referral and use of effective traditional herbal medicine.

(b) A substantial number of dais have come forward for training at the Kendra. As a result of training, they integrate their traditional skills with scientific knowledge, in care of the mother and the child, which has resulted in nil maternal mortality, drastic reduction in infant mortality, virtual disappearance of neonatal tetanus, combined with, skillful deliveries of complicated cases using their traditional skills without a single case of caesarean section being done.

(c) Most of the tribal children are immunized against diphtheria, pertussis, tetanus and polio. Oral rehydration therapy is used extensively, and this has dramatically reduced diarhoel deaths. Several villages have taken action for periodic cleaning of drinking water ponds and streams.

(d) Village health workers and dais are not paid salaries. Voluntary health workers are only reimbursed the bus fare for travel to the base hospital for the ongoing training two days every month. They do health work after their usual work at their occupation, during the evening hours.

(e) The response to leprosy control programme launched by the Kendra is very good. 85 - 95% of all villagers came forward for the clinical examination after being educated on the problems of leprosy.

(ii) Nutrition :

Children from neighbouring hamlets are brought to the Anganawadis in the project area for the mid-day meals at the Community kitchen which serves the Anganawadi located at Kendra headquarters and the Kendra staff as well as the school children and school staff. The daily requirement of vegetables is substantially met from its vegetable garden, in which the labour is almost totally derived from the volunteers among the vocational training centre trainees, the residential school students and other resident tribals of the neighbouring hamlets. Firewood for Community Kitchen is collected from the neighbouring forests by the school students, on account of which the Kendra is able to feed a nutritious meal at low cost to pregnant and lactating mothes and underfive children.

(iii) Community Organizations :

Adult education focussing in social awareness and social responsibilities including health of the community, has resulted in development of community organizations. The Sanghas interact freely with the government officials for the development of the community. These Sanghas became the key channels through which most of the health actions, for example, cleaning of ponds is initiated in the community. The travel costs, part expenses of leadership training programmes conducted for the Sangha leaders, are funded by a monthly contribution of one rupee per family which is collected by the Sanghas.

(iv) Housing :

The people have initiated and successfully got houses constructed for themselves as per budgetary provision. The Sangha leaders assisted by the social workers, are instrumental in mobilizing popular support for houses to be constructed for the more under - privileged and landless tribals, rather than the landed or better-off tribals.

RESULTS

The result has been an unprecedented participation by the tribal community in all fields of development. Skills, attitudes and awareness pertaining to modern civilization have been assimilated into the fabric of their existence. For example, health has become a way of life. Formal education which was alien to their tribal culture is now well accepted by the community as a necessary part of a progressive way of life. Specifically, the results and achievements of the project, in the various fields of activity have been as follows :

A. Health

About 13,000 outpatients and about 200 inpatients are treated every year at the base hospital. Cases of snake bite, injuries including major fractures, which

were formerly accepted as a part of life in a fatalistic manner, are today increasingly, brought directly to the hospital, or referred by the village health workers.

As a result of the systematic screening programme for sickle cell anemia, 27% of 2,000 people were identified to have sickle cell trait, 2% are known to have sickle cell anemia. Systematic follow-up and treatment of sickle cell crisis is being done. The health education programme lay stress on consuming forest fruit and leafy vegetables rich in folic acid to compensate for the sickle cell disease process. About sixteen to eighteen thousand sick people are being contacted and treated through mobile medical work.

As a result of the activities of the village health workers and traditional birth attendants working in the community, there is high immunization coverage for children, dramatic decrease in diarrhoeal deaths over the past five years, virtual eradication of scabies, very good compliance of the community in detection and treatment of leprosy cases, virtual disappearance of neonatal tetanus, and almost nil incidence of maternal mortality from a situation of very high incidence of maternal mortality at the time of commencement of the project. Prevalence of malnutrition has come down from 50% among children to about 15%.

As a result of house surgeons' training in community health with a community participatory approach, two of the doctors, Dr. Maheshwara and Dr. Balasubramaniam have started similar tribals development projects on their own in Bandipur area and H.D.Kote.

About 570 cases of leprosy was diagnosed and their compliance for treatment is very high owing to the active involvement of the community in motivating the patients for regular treatment.

B.Education

Literacy and informed action for their own development, is evident in the independent manner in which tribal leaders (formal and informal), communicate with governmental agencies (Forest Department, Social Welfare Department,etc). They themselves even address communications to the State Government Secretariat in Bangalore. While the results of adult education effort is evident among the adults, about 520 children study in the school run by the Kendra at nursery,, primary and middle school and high school levels. These students, serve the Kendra with their labour in the kitchen gardens to raise vegetables for the combined kitchen serving the staff, school and Anganvadi children gathering firewood etc. They are also well ahead in formal education. The children with the guidance of the Educator Manufacturers Association (EDMA) have made a reflecting telescope from the basic materials available. Their participation in the Annual State Level Science Exhibition organised at Bangalore, resulted in this Tribal School being awarded the third prize at the State level.

C. Community Organization

As a result of community organization, most of the alienated lands of the tribals was restored to them. They were able to mobilize the support of other nontribal communities in Kullur for restoration of their lands. In Muneshwara, colony the women fought for their land which was under threat from the forest department. The Soligas were able, by their organized effort and agitation, to

insist, that the Forest Department employ the Soligas to plant trees rather than outside labourers. Tamarind trees were a source of income, for some of the Soligas, and they were being exploited by rich contractors in Budipadaga who got the crop for a meagre sum of 10 to 15 rupees per tree per year, and sold it for about 500 rupees; this exploitation was maintained by the contractors through violence. As a result of education and community organization of the Soligas on this issue, they collectively decided to repossess their trees and they fought effectively, resulting in return of effective ownership of their tamarind trees with each tree fetching them rupees 400 to 500 per tree per year.

As a result of community organization, the utilization of budget under tribal sub-plan for appropriate purposes has been almost hundred percent.

D. Cottage Industries and Vocational Training

At the Vocational Training centre, about 68 women, and three young men are trained in Agarabatti making. 2,000 sticks per day are rolled out by the women in their homes, after their household work. The agarabatti is marketed thro' the Co-operative Society out-let. Fifteen women have been trained to make coir ropes and other coir products'; the sale of these products has added to the income of many families. As a result of bakery training, not only is the Kendra bakery run independently by two tribal youths, but, one of the youths trained at bakery work has been able to run an independent unit at Bedaguli, which is a remote village in the forest. Cloth weaving, mat weaving and other crafts have become a systematic occupation of the Soligas and has improved the income of many families. Similarly, organized collection and sale of honey has improved their income from bee-keeping by three to four times.

E. Housing :

Totally about 70 good low-cost houses have been built in collaboration with Government housing programmes. The Community participates in all these housing programmes with voluntary labour to enable larger number of low cost houses to be built within the sanctioned budget. Of late, the housing programme has been totally made over to the community.

COLLABORATION AND CONFLICTS

A. Conflicts with Government, and certain vested interest groups:

The major conflict and resistance came from the forest department and landlords who had illegally occupied the forest land, and, contractors of forest produce such as tamarind, honey and timber who used to exploit the tribals. By a combination of organized efforts at persuasion and agitation, these issues were successfully fought out by the tribals.

The awareness and prompt protest by the tribals against illegal felling of trees and smuggling of timber by forest smugglers in collusion with forest department officials, has resulted in frequent conflicts between the forest department and the Soligas.

B. Conflicts with the Community:

Since the philosophy of the project stressed on community participation in all decisions, there was not much conflict between the Vivekananda Girijana Kalyana Kendra workers and the community, once the initial rapport was established with them.

Besides, the Soligas were a fairly homogenous community with a culture of sharing equally and almost no vested interest groups. They had had very little contact with non-tribal population including Governmental or other agencies (other than Forest department). Hence feelings of hostility based on past bad experiences, which tend to complicate efforts of voluntary health agencies, were minimal. On the whole, there was no conflict between the Kendra and the community.

C. Collaboration with Governmental Agencies :

Over a period of time, after the initial conflict the Kendra had with the Forest Department, collaboration with the Governmental agencies has predominated. The Kendra has been associated with proper channelisation of funds allocated to the taluk for education, vocational training, cottage industry, development and afforestation, under the Departments of Education, Forestry, Industries, Health and Social Welfare, of the Government of Karnataka as well as the funds of co-operative banks in the area. Thus there is no duplication of work or programmes vis-a-vis the governmental agencies.

(a) Health : Initially when the Kendra started work in the area, there was almost no contact between tribals and the Government Health Centres which was expected to cover the area. The Kendra concentrated on preventive and promotive work, MCH, immunization and prevention of waterborne diseases. It is generally known that the governmental health workers concentrate on family planning work, while the Kendra concentrates on preventive and promotive services other than family planning. In fact, the development work done by the Kendra has facilitated the success of family programmes among the tribals of this area. Vaccines for antenatal and child immunization are obtained from the Primary Health Centres and Primary Health Units covering this area. Finance for the nutritious midday meal for pregnant mothers and underfives are met with chiefly from the funds under ICDS. The Anganawadi teachers of this area are paid under the ICDS scheme, but Anganwadis are managed and guided by the Kendra organization. Drugs for Leprosy Control Programme are procured from the District Leprosy Officer. The process of integrating the area Leprosy workers under the Government, into the Leprosy Eradication Project of Vivekananda Girijana Kalyana Kendra, to avoid duplication of work/staff and utilize their services in a planned manner, is underway.

(b) Other Activities : The school managed by the Kendra and located at the Kendra headquarters is maintained from the budgetary allocation for the area, of the Department of Education. The Vocational Training Programmes which are carried out throughout the year at the VGKK Vocational Training Centre, are conducted with the financial assistance of District Industries Centre, Government of Karnataka. The tribals are employed by the forest department under the afforestation budget. Subsidised loans from the Karnataka Co-opeative bank are

utilised for various small entrepreneurial ventures started by the tribals after suitable training at the Kendra and these enterprises are supported by continuous guidance and technical assistance from the Kendra.

For example, in Kollegal taluk, under the Tribal sub-plan 1986-87, the taluk was allotted Rs. 42,58,410/- for various developmental works. This was to materialise after passing through various departments. The Sanghas, catalyzed and supported in their activities by the Kendra leaders, worked to ensure that the full benefits of the programme reached eligible tribal people; this was achieved through the direct contact achieved by the sanghas with the Governmental agencies even upto Secretariat level at the State Capital of Bangalore.

(c) Housing : In collaboration with the government housing programme, forty low cost houses at Banglipodu and Purani have been constructed. At Yerakanagadde colony, thirty houses have been repaired and improved. The forest department is also constructing low cost houses under the Tribal Rehabilitation budget after being persuaded by the people. In addition,the Soligas, through their Sanghas have been able to get such facilities as old age pension benefits, training programme,rural development programmes, housing schemes and help in agricultural improvement. The Kendra is actively involved with the Zilla Parishat at district level, and is a member of the consultative group at the State level.

(d) Contact Meetings : Contact meetings are organized every month between Government Education Officers who take decisions on developmental matters, Forest officers, etc. and the Village Sangha leaders and Kendra leaders. On the third of every month, at this open forum, information is exchanged, clarification sought and given on allocations, and implementation of the programmes in the respective villages. Discussions take place to arrive at a consensus to change orthodox Government Programmes to suit tribal practices, skills and environment. For example the Government Rural Development Programme sought to provide milch animals to tribals under subsidized loan scheme. But milch animals were known to be affected by liver disease on consuming the locally available forest grass. Conventional fodder could not be afforded by tribals. So, by discussion with Government officers and following it up at higher levels, they got it changed, to be provided with goats. Similarly other suitable schemes were implemented by consensus under this budget.

(e) In liaison with the Centre for Ecological Sciences of the Indian Institute of Science, Bangalore and the Karnataka State Council for Science and Technology, an action-research project on environmentally sound development planning models has been initiated, so as to study and incorporate ecological factors in the area development process. These efforts are expected to provide other development agencies with a model and inspiration for similar efforts elsewhere.

D.Collaboration with other Voluntary Agencies:

In many of its activities, including gaining expertise for the action-research project, the Kendra is informally supported by voluntary agencies all over the country, working for a similar cause.

FINANCIALRESOURCES

The project was initially funded by various foreign agencies chiefly, the Christian Children's fund, HIVOS and several other individuals. Most of the recurring expenditure for the various activities is met with from the government budget under the

various schemes. The financial requirement for creation of physical facilities, buildings, purchase of lands, equipment and vehicles, are met by donations from industrialists, charitable institutions and other voluntary contributions from distant cities. However, labour is contributed by tribals to a large extent. For the following specific activities, funding is as follows :

(a) Nutrition : Met with by budget under Integrated Child Development Scheme of the Department of Social Welfare, and Child Sponsorship Scheme of the Christian Children's Fund.

(b) Education : The recurring expenditure on salaries for school teachers, textbooks, etc., from Education Department budget for the area. The educational needs of the children are helped by the Child Sponsorship Scheme.

(c) Adult Education : Government budget sanctioned for adult education in the area, is being channelised through the Kendra.

(d) Vocational Training: Funded by District Industries Centre, Government of Karnataka.

(e) Training : Most of the developmental activities including health, development of leadership and socio-economic change revolve around training. About half the cost of conducting the leadership training camps are met by Sanghas which collect a monthly contribution of one rupee per family.

(f) Community Organization Activities : Community organization activities requiring travel to meet Government officials etc, are funded through the collection of one rupee per family by the Sanghas at the village level.

(g) Socio-economic change : Some grants from the Ministry of Social Welfare are utilized for various activities. Funds requested by the community for specific purposes are provided by the Forest Department for socio-economic development of the Soligas.

The above sources are more a form of liaison with Government, rather than an alternative source of funding. The funds received apart from the above sources for the year 1988-89 were of the order of Rs.8 lakhs which was raised to fill in the gaps between Government budget under the various heads, and the requirements for integrated development activity.

FACTORS IN THE SUCCESS OF THE PROJECT

A. Organizational Factors

1. Positive factors

(i) The project started with one person who was very clear in the goal - that of promoting the welfare of tribals in the context of self reliance of the tribals to work

for their own development. This led to the change agent, adopting the role of catalyst for change, rather than as an outsider imposing a standard model of developmental and health programmes on the community. Dr. Sudarshan and the other early pioneers lived under very trying circumstances, often semi starved and persisted in living with the community to make them self reliant and aware, and help them to develop their own model of development.

(ii) The strong leadership combined with a commitment to participative decision-making keeping in mind the felt needs of the community, resulted in high degree of community participation in all the health and development programmes within a very short period.

(iii) The ability of the leaders to utilize the strengths of the Soliga community and build on it - the strong sense of community life and sharing, and lack of groupism among themselves. Thus the Soligas were collectively mobilized and readily organised for community-based, rather than, mere family- based participation.

(iv) The ability of the leaders to attract committed health professionals and para professionals, social workers and other relevant development workers, e.g., the vocational training centre trainers, to take responsibilities in their respective areas, and their ability to motivate them to function in the spirit of community participation, was a major factor in achieving comprehensive all-round development.

(v) The emphasis on developing leadership and other skills among the tribals to take over the complete management of the development process themselves in due course, resulted in high degree of participation and self-reliance.

2. Constraints

The persons who initiated the project were total outsiders to this community. The people shied away from all contact in the beginning and it took some time for the project leader to gain the confidence of the tribals.

B. Community Factors

(i) These tribals were a small closed community without much experience of contact with non-tribals. This was a positive factor which permitted Dr. Sudarshan to work with them relatively easily. For instance, when government health workers try to promote family planning without adequate education of the community, and in the course of this if some death, or untoward side effects occur, this tends to cause lot of resentment against the health establishment. This has been a common experience of volutary agencies which try to work for health in many parts of the country. In B.R.Hills, there was almost no previous contact between tribals and the health establishment . This led to Dr. Sudarshan and his team to be readily accepted.

(ii) The community was almost homogeneous with few or no vested interest groups. Community life based on an attitude of sharing, was the rule. This could have facilitated the community participatory approach to development, attempted by the Kendra leadership, and it tended naturally towards a process of shared development benefits. Some constraints related to more powerful persons in the community trying to corner the benefits, did come up from time to time, but it was not a serious problem.

Case Study :IX

ACTION FOR WELFARE AND AWAKENING IN RURAL ENVIRONMENT - AWARE

AWARE (Action for Welfare and Awakening in Rural Environment) started working with tribals and Harijans of a few villages of Andhra Pradesh to enable them to participate actively in the developmental process and programmes initiated by the Government. Mr P K S Madhavan, started the project on a very small scale in 1975 after leaving the government service to serve the poor. He started working single-handed in a few villages and now the project covers over one million tribals and Harijans in the State.

A situation similar to that of the Soligas of B R Hills was prevalent here. The tribals were being marginalised and deprived of their traditional forest resource base which supported their simple nutritional needs and a simple living. Development was taking place all around them from which they remained isolated due to their culture and simplicity, and with the added imposition of the forest laws they became outcastes in their own homeland. Contrary to the Soligas however, there was a major problem of almost 100% alcoholism among these tribals which killed all initiative, and which was the major challenge for the AWARE leadership.

The following gives an account of the organizational leadership of AWARE in tackling one of the most recalcitrant problems known to civilization, namely, the task of development and promotion of self-reliance among communities exploited for centuries, and enmasse addicted to alcohol.

THE COMMUNITY SERVED

AWARE directly caters to the needs of Harijans and tribals of about 3,000 villages in Districts of Mahabubnagar, Khammam (where maximum concentration of tribals is to be found in the State of Andhra Pradesh), West Godavari, and Krishna Districts, a total target population of one million. The maximum number of villages where AWARE is active is in Khammam district, which has a very large tribal population and where, at the time of inception of the Project, the District Collector was highly enthusiastic and extended all cooperation for the activities. In addition about three villages near Hyderabad in Mahabubnagar district, about 80 remote villages in Godavari Delta which can be reached only by boats across the river tributaries, a few villages in Krishna district, are also served by AWARE.

At the time of inception of the Project, the hill tribals were facing deteriorating economic conditions owing to the socio-economic development going on around them which they were not a part of. Being tribals they traditionally subsisted on forests, living on the produce of shifting cultivation and hunting small game. With increasing tribal population and encroachment of the forests by landlords to convert the forest land into agricultural land, deforestation by vested interests, forest laws prohibiting tribals from living their traditional lives, tribals were faced with an extremely tight situation. A few tribes, owing to their backward conditions and very high maternal and child mortality rates, were

already known to be dwindling in numbers. Malnutrition and increasing poverty was added to this. The life expectancy at birth among them was about 40 years as compared with the average Indian's life expectancy of 54.4. The most important hurdle to their development was addiction to alcohol, particularly among the men, which was almost 100%. Alcohol intoxication even during daytime, prevented any productive work or development. Women worked on the land and gathered game for the family.

The tribals of the plains live in hamlets well away from the main villages, as outcastes with petty occupations living in extreme poverty. The Harijans (or scheduled castes) are outcastes in the villages making a living by scavenging and other similar occupations.

THE PROJECT : PHILOSOPHY, BEGINNING AND OBJECTIVES

The project was begun by Mr P K S Madhavan, a young anthropologist, who was working as a civil servant in the Planning Commission and left the government service to find a way to serve the people better. In the course of studying the development plans for the tribals, he discovered that a large amount of money had been spent, down the years on tribal development. On tracking down the government spending and visiting the tribal areas, he found that as much as 62% was spent on maintaining the bureaucracy, with barely 7% reaching the tribals. Another 5% was misused by the tribals themselves on alcohol and social festivals. After a long experimentation with a secluded monk-like life for about 4 years during which his concern for the tribals was increasing, in 1975, he along with like minded persons Mr V Kumar and Mr B Babu Rao, registered AWARE under the Societies' Act - with the broad objective of bringing the development processes and benefits closer to the people who had experienced them least, i.e., the tribals and the Harijans. In the course of trying to find funds for his Project and a suitable tribal area to start the activities, he came across the Community Aid Abroad (a funding agency of Australia) and an encouraging collaborator in the District Collector of Khammam. With the help of these inputs, the AWARE, which was conducting some awareness activities in three villages near Hyderabad, began a full scale Project in tribal areas of Khammam with the objectives of -

(i) Psychological mainstreaming of the Harijans and tribals through intensive awareness and community organization programme.

(ii) Socio-economic development of the Harijans in the true spirit of community participation, in the sense that the need for development and actions for development should come from the people, AWARE being an awakening and catalytic agency.

(iii) To make the people self-reliant on the path of socioeconomic development, and , subsequently withdraw from the area once this is achieved.

The key intervention AWARE seeks to make, is one of, psychological empowerment of the people.

PROCESS OF PROJECT IMPLEMENTATION

The project seeks to create awareness and empower the tribals and Harijans (oppressed castes) for development. It is a continuously expanding project with its target population restricted to tribals of both the hills and the plains and the

harijans in the villages covered. Beginning with creation of awareness, AWARE catalyses the socio-economic developmental needs in the area as and how these emerge from the people as felt needs In areas where health has emerged as a felt need, the health programme is started as part of the comprehensive developmental activities.

While implementing a new area the following activities are carried out in a sequence :

i) Awareness building and community organization programmes

(ii) Income and employment generation programmes.

(iii) A basic needs Programme including health wherever the need was felt by the Community.

The AWARE rural organizers seek out a village and conduct informal meetings with the villagers. Thus awareness and interest to form a Village Association is created. The first and foremost stress is laid on the evils of alcohol, and once awareness is created in the villagers of the need for development, they are persuaded to give up alcohol, as the first step that needs to be taken for development.

Each Village Association under the leadership and guidance of AWARE rural organizers and the local tribal trained to be organizer, submits a Comprehensive Village Development Plan annually to the Cluster Development Officer (CDOs), who is responsible for about 15-20 villages with a total target population of about 3000 - 4000. Four to five CDOs are coordinated by the Area Development Officers (ADOs). The ADOs and CDOs meet at the AWARE headquarters with the Project leaders and, in keeping with the budget and the priorities as laid down by the Village Association/allocations are made. The budget for the areas are finalized based on the following :

(i) The Government budget allocation under the various heads for the particular area; (ii) the present availability of the Corpus fund which was created from funds from the donor agencies - a standard amount of Rs. 15 lakhs set apart for each cluster when the area is taken up; (iii) the amount recovered from previous expenditure on economic programmes in the area (Revolving fund). If the Corpus fund has diminished due to too many loans in previous years, and non-repayment of loans , their budget for the next year is automatically decreased.

All expenditure on economic programmes is treated as loans to the community. The individual family or group beneficiaries are to repay it, interest free, in a reasonable time schedule. Allowances are made for crop failures or other natural calamities. The organizer at the village level, the CDO at the cluster level and the Area Co-ordinating Officers at the Area level (about 5 to 6 clusters form an area), are responsible to organize the villagers, prepare the detailed plans and guide the Associations in identifying priority areas of development, identifying the most deserving beneficiaries, ensuring proper repayment of the loan. The loan repayments enter the Revolving fund. The future budget and therefore development of the village depends partly on the repayment, which acts as an impetus for the village leaders and organisers to ensure proper utilization of the loan for productive purposes and repayment.

All awareness programmes and leadership programmes for the villagers to lead the community for the various programmes, are conducted by the Organizer aided by the CDO and the ADO. The Organizers themselves are persons selected from the villages during the awareness creation activities done in the early period of entry of AWARE into the area. Organizers are trained intensively over a period of six weeks. The training is conducted at the AWARE Training Institute located about 20 kms from Hyderabad. Moral commitment to the cause, a spiritual way of life to sustain the person, technical and administrative skills for the various socio-economic programmes, etc., form the thrust of the training programmes which are largely headed by Mr. Madhavan.

Candidates selected to become CDOs, ADOs, in short, any field staff who aspires to work for AWARE is put through the Programme.

The Health Programme:

Health programmes are initiated in areas where there is a felt need for a health centre and the Village Associations come forward to take up certain responsibilities. In Khammam district, where high prevalence of leprosy was noted, a Community Health Centre with a leprosy Rehabilitation Centre attached to it was started. Totally five Community Health Centres are functioning as referral base hospitals with 30 beds and operating theatre facilities. The Village Health Workers are selected from the community and provide elementary curative services, maternal and child care, motivation for family planning and other services VHWs of villages surrounding the CHC are trained at the CHC by the doctor and nurse. Each CHC serves as base hospital to about 20-30 neighbouring villages.

The Boat Hospital and the associated Konavaram Base Hospital serve 80 villages with a population of about 40,000 on the river Godavari These villages are inaccessible by road and can only be reached by boat VHWs in these villages, again, provide the first level of health care, and emergent cases are brought to the "Health Shelters" on the bank where the Boat Hospital, stops on every alternate day to treat the patients Difficult deliveries are conducted on the boat; minor surgery, immunization, antenatal and postnatal checkups, etc , are conducted. The dais of the area are also trained through informal education and training during the health and medical care activities being carried out during the brief stopover of the boat hospital In addition, the doctor and the paramedical workers, during their free time conduct health education sessions with village elders to initiate chlorination of wells, sanitation and drainage systems etc., by the community, which are then coordinated with the governmental agencies to implement these programmes.

At each Community Health Centre, two doctors - the Director and the Asst Director both trained in Community Medicine in addition to basic medical qualification are posted. Each heads one team. One team attends to the hospital work and training at the base Hospital, the other team works in the field conducting health awareness camps, selecting potential women candidates to be trained as VHW, guiding VHWs in their work ,conducting village health clinics, identifying dais for training, etc. Both the teams do the field work and the Base Hospital work by rotation.

A modest delivery kit to provide safe delivery service is given to every trained dai.

The CHCs are located at five places Attached to Naidupet (in Khammam District) is a Leprosy Rehabilitation Centre where complete facilities for treatment, physiotherapy, vocational training and social rehabilitation for Leprosy patients are available. Kunavaram (the base hospital for the Boat Hospital and the 80 villages served by it), Padakal, Chinnapuram, and Narayanapura are the other four locations of CHCs. Chinnapuram CHC is located 400 kms from Hyderabad in Krishna District and it was started in continuation of the Cyclone Relief Centre opened by AWARE in 1979 to provide relief and medical care to the people hit by the tidal wave and floods. Even after the people had recovered from the disaster, at their request, AWARE opened a permanent health centre.

At all CHCs, services are provided free of cost. Only a nominal fee is charged for medicines (at cost price); even that is waived in case of deserving and very poor families. The community organisation and awareness in the target families is such that most families not only pay for medicines but also contribute towards the maintenance of the Centre. In the case of Naidupet CHC with the attached Leprosy Centre, villages in the surrounding areas contribute for drugs and rehabilitation of leprosy patients.

Thus all programmes of AWARE, whether socio-economic or health programmes are based on creating awareness in the community, creation of a community-based cadre of workers and empowering the community.

Project Withdrawal :

AWARE remains intensively active in an area for a period of about five to ten years with full time Project staff, creating awareness and initiating the programmes, next assisting and facilitating the villagers to handle the programmes themselves - ranging from getting loans from banks and other sources to ensuring repayment, to imparting technical skills to beneficiaries etc. Once the Village Associations and leaders show signs of being able to handle their own development, AWARE starts winding up operations, during which, at first the local organizers are no longer paid as staff, as they are now expected to be maintained by the Village Association. The Cluster Development Officers now only guide the formation of the Village Development Service Societies to take over the planning and coordination functioning which was performed by AWARE. With progressive stability of the village societies, they themselves form a Cluster Development Society with elected functionaries, and the CDOs of AWARE are withdrawn, with the Area Coordinating Officer assisting. Next the Cluster Development Societies elect a locally based Area Development Officer who takes responsibility of guiding, planning budgeting the plans and coordinating with the Government for the development programmes, and the Area Development Officer of AWARE is withdrawn. However, in the case of the health sector, the withdrawal has not been possible. Health expenditure is non-recoverable and the health organizations costs continue to be borne by AWARE.

In this manner, out of a total of about 3,000 villages where AWARE has started functioning , it has been able to pull out of 200 villages. The Cluster Development Societies continue to approach AWARE for occasional guidance.

ACTIVITIES

A. Socio-Economic Activities

1. Awareness and Adult Education Programmes

Village meetings are conducted with groups and individuals by the AWARE rural organizers to educate the Community on the evils of alcohol and alcohol related indebtedness and bonded labour; the organizers bring out the need to abandon alcohol, and help the individuals to give up alcohol. Once the majority of the tribal community gets de-addicted from alcohol, the community meetings next concentrate on income generation schemes, employment with help of the Government programmes - the Integrated Rural Development Programme, Tribal Rehabilitation Programme, the Food-for-Work programmes, etc.

Adult education for functional literacy, creation of awareness of loan schemes from banks and Governmental institutions for poultry and other agricultural activities; health education, are also carried out.

2. Agriculture Development:

Technical and financial support to irrigation programmes for digging wells, deepening and improvement, minor irrigation works such as tanks and check-bunds; lift irrigation and pumpsets on a cooperative basis; soil conservation techniques; popularization and propagation of modern methods of farming through facilitating good quality seeds and fertilizers; initiation of the tribals and Harijans to animal husbandry - an occupation alien to them, are some of the activities. Goat-shed building, rearing of goats and poultry farming are also initiated.

Marketing co-operatives to enable them to sell the produce at fair prices are also set up, gradually involving the local tribals to manage the entire operations themselves. For all these activities the tribals are assisted to avail the government loan facilities and budgets, in addition to being given loans from the AWARE Corpus Fund and Revolving fund. The Revolving Fund is created purely out of loan repayments by previous beneficiaries.

3. Cottage Industries and Vocational Training

Small scale cottage industries are set up by AWARE to enable landless tribals to make baskets, shoes, leaf plates and pottery and earn a living.

The Rural Vocational Training Centre has been set up at Aswarapet in Khammam District exclusively for tribal youth to train them as carpenters, fitters, diesel mechanics, welders and electrical mechanics. These trades have been selected so that the supportive services in villages required for agriculture, like repairs of pumpsets and making of agricultural implements, servicing of machines can be provided by this cadre, without requiring them to migrate to the cities to search for jobs.

4. Legal Cell

A Legal Cell functions as a wing of AWARE composed of legal officers, consultants, social activists, and finally the barefoot legal workers from the community trained in legal aspects, to fight for their rights through judicial procedures. Bonded labour, exploitation of tribals and encroachment of scheduled tribal land by the well-off farmers and city dwellers, are some issues successfully fought and won, in several areas.

B. Health Activities

1. At the Village Health Workers level

In the course of awareness programme health messages are also communicated including the need for maternal and child health, safe delivery practices, sanitation, personal hygiene, protected water supply, prevention of scabies etc. As the village Association and Community groups realize the enormity of the health problem, they along with the AWARE's Organizer, identify suitable tribal women (mostly illiterate but with some leadership qualities) to be trained as VHWs. These VHWs take up the work of promoting and maintaining health of the Community. Her activities are as follows :

(i) Identification, prevention and treatment of seasonal diseases and simple diseases

(ii) Bring about liaison between dais in the Community and the CHC for training of dais.

(iii) Motivate the community to accept family planning, immunization and other MCH services.

(iv) Refer ill patients, antenatal cases, postnatal cases, severe malnutrition, etc. to the Base Hospital (or in the case of Godavari area to the Boat Hospital)

(v) Motivate the community to organize environmental sanitation and safe drinking water supply sources.

2. At the Paramedical Workers level

Paramedical workers, are trained for six months at the CHC. They are either posted at the CHC to carry out hospital work including out-patient and inpatient services, preventive health services and health training to VHWs and dais, or posted to each of the Health out-posts or Shelters to provide basic medical care and immunization.

3. At the CHC level, the activities are as follows

a. Curative care including in-patient care

b. Preventive services - immunization, MCH and health education

c. Training of the Village Health Workers and the paramedical staff

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

All levels of functionaries among the AWARE staff attribute the remarkable success of AWARE, both in terms of impact and scale of operations, to the leadership of Mr P K S Madhavan and his selfless dedication to the objective. He built up the AWARE organization from an initial group of three individuals to its present (dedicated) staff strength of 700, and he could lead the AWARE to extend its zone of influence from the initial three villages near Hyderabad catering to a few hundred population, to nearly one million tribals and harijans in Andhra State. In addition, out-reach projects were started independently by workers trained for two years at AWARE's projects. These outreach projects are functioning in tribal areas of Raichur districts of Karnataka, parts of Kerala, Orissa and Tamil Nadu. These outreach projects also derive leadership and support from theAWARE.

The organization is headed by the Chairman Mr K P S Madhavan. The Chairman remains in contact with the Community through intensive touring and particularly through the mahasabhas convened once in a year which are organized for every cluster, to bring together the AWARE Project staff, the Village Associations of each cluster, volunteers of these villages and any villager who wishes to communicate needs or grievances. The organizational structure is as shown in the figure.

All AWARE staff including the Village Organizers are trained intensively for atleast six weeks in the Headquarters. The first two weeks training is under the leadership of Mr P K S Madhavan to ingrain the spirit of the Project objectives into every worker. This is followed up by the technical and communication aspects of rural development. Village organizers train other persons in the community for specific types of work relating to the different programmes. The CDO and ADOs conduct a minimum of six training programmes in a year in their area for rural and village organizers, volunteers, community animators etc, in leadership, technical and communication skills.

Chairman
|
Project Director

Administrative Section

Planning Section
Officer & supportive staff

District Head
Administrative Officer
Planning Officer
|
Administrative Officer for each sector of the district supervising 3-4 areas and their ADOs
|
Area Development Offcerrs each coordinating and supervising 5-6 clusters
|
Cluster Development Offr each coordinating and supervising 15-20 villages
|
400 full time Rural organisers
|
800 village organizers - part time (one for each village, tribal/harijan. trained at HQ)
|
Village Association Workers other voluntary village workers - 25,000

Health Programme
|
Community Development centre
|
Director
|
Asst.Director
|
Paramedical Workers
|
Village Dais Health Workers

In addition to the Founder's leadership, second line leader ship is provided by the Project Director and almost every field staff Today the leadership at the village level is provided by thousands of Organizers who are tribals and harijans.

and by the Rural Organizers of AWARE, at the Cluster and Area level by the intermediate level AWARE staff.

PROCESS OF COMMUNITY PARTICIPATION

A. Socio-economic Programmes

1. The Community participates in the socioeconomic programmes right from planning through executing and administering the programme

The Village Association with guidance of the AWARE's rural organizations and CDO, plan in detail the particular economic development programmes to be pursued in each year, item wise. For instance, the priorities regarding digging of wells, irrigation schemes, seed supply and animal husbandry etc are laid down in the annual plan along with the budget required. The beneficiaries of loan for the year are identified by them. Ensuring proper utilization of the loans for the specific purpose and prompt repayment by the beneficiaries is also their responsibility.

The success of this scheme of turnover of funds is evident in the improvement of the general socio-economic status. A Corpus fund of rupees fifteen lakhs for each Area of about 100 villages with a target population of about 20,000-40,000 is created from overseas donations. From the loans disbursed, the recovered amount, thereafter entering the Revolving Fund contributes to about 40% of the total budget while 60% is from the Corpus fund. Totally the community repays about 80% of loans given for economic activities. Thus, through community participation and responsibility in the development process, dependence on continued external assistance is progressively being reduced.

2. About 25,000 village volunteers entirely unpaid by the Project are working actively in their communities on the development programmes.

3. In about 200 villages, AWARE has withdrawn completely, and a full scale development organization has been created entirely from the community. They have been carrying on the activities independently, including negotiations with the governmental agencies for loans, proper implementation of IRDP, food-for-work and other schemes.

4. In about 844 villages, Community Education Centres are being run. These centres are opened only after the community turns in a deposit of Rs. 250/- with AWARE, and constructs a shed for conducting the classes.

B. Health

1. Village Health Workers are women selected from the community who work for health - being paid a monthly honorarium of Rs.250/-. AWARE is attempting to make them responsible in such a way, that a case of preventable sickness or ill-health arising in the community becomes the VHWs responsibility.

2. The Health Shelters constructed along the banks of the Godavari to serve as health posts are largely built with local voluntary labour.

3. The community in the vicinity of the Naidupet community Health Centre with the Leprosy Rehabilitation Centre attached to it, contributes for the medicines for leprosy patients.

4. The community, in fact, through payments and personal contribution for services rendered, pays for about 24% of the total budget of AWARE; approximately one crore rupees is raised annually from the AWARE's project area, for further activities and expansion of scope of AWARE. This contribution has been increasing to the extent that, in 1986-87 it was four times what it was two years ago.

RESULTS

The process of transformation of the tribals and harijans from oppressed , exploited groups, to self reliant communities has been based on the strategy of sustained action for creation of awareness among tribals, and support to them to pursue the path of development, in terms of moral, social and economic support. All activities are planned keeping in view the ultimate goal of tribals and harijans welfare and self reliance.

With this view, any programme has to emerge from the people as a felt need; after initial help, support and facilitation, the economic and social programmes have to be taken over by the people themselves. The people are responsible for future maintenance of any economic programme through responsible administration of the funds and the community which utilizes it.

The result has been a remarkable change in socioeconomic and health status of the tribals and Harijans in the AWARE project area.

A. Socio-Economic Development

(i) About 1000 tribal villages in AWARE project area have been declared liquor free, from a situation of almost 100% addiction to alcohol among men in these villages in 1975.

(ii) Market awareness, high degree of school enrollment, productive activity among the people and a general awakening to the concept of self-reliance for development is evident.

(iii) Organization Building : About 1,750 village associations are active in the Project areas taking increasing responsibility for community development. As a part of the AWARE's withdrawal process, about 100 Cluster Development Societies and 10 Taluka Development Societies have been formed to take over macro level management of tribal development.

(iv) Social Education : So far about 760 training camps for development of leadership, technical skills and communication skills for community Volunteers to work for development and health have been conducted. 844 Community Education Centres have been set up.

(v) About 4,700 acres have been recovered from illegal encroachment for use by harijans and tribals through legal means. About 23,320 acres of unexploited land has been brought under cultivation, 27 irrigation tanks have been con-

structed, 1,214 milch animals provided through loan and subsidy and a total of about Rs. 3,903 crores has been given as loans (about 40% of it through recycling on repayment), so far. About 5,000 bonded labourers have been released and rehabilitated.

(vi) Through the above programmes, about 7,20,093 population has been benefited including 7,275 landless families.

(vii) In addition, a great deal of cyclone relief activity has been done.

B. Health

1. Health Indicators :

The crude birth rate in the Project area has gone down from 32 per 1,000 in 1979 to about 30.8 in 1986, crude death rate has

gone down from 14.2 per thousand to 10, infant mortality decreased from 110/1000 live births to 65/1000 live births, child mortality (1-5 years) from 85 to 68 per thousand. Life expectancy has gone up from an estimated 40 years to about 55 years.

2. Service Data :

Coverage of the population for the various services and utilization has increased.

Antenatal registration has gone up from 5-10% in 1979 to about 50% in 1986, deliveries conducted by trained health workers has gone up from 3% to 30%, institutional deliveries from 2% to 25%, Couple protection rate from 20% to 33%, immunization coverage among children and antenatal cases from 4% to 40%, children covered by child welfare services from nil to 35%; growth monitoring is being done for about 50% of underfives; children with normal nutritional status has gone up from 10% to 30% and number of underfive children with severe undernutrition has gone down from 88% to 60%.

These changes are particularly marked in project areas of AWARE in Khammam district and the areas covered by Padkal CHC in Mahabubnagar District.

COLLABORATION AND CONFLICTS

A. Collaboration with the Government

1. AWARE began its activities in Khammam District with the support and sustenance given by the district administration under the District Collector who was committed to tribal and harijan welfare. In addition, the District Collector of Mahabubnagar also invited AWARE to begin activities with the help of government funds and infrastructure allocated for tribal welfare.

AWARE has mostly solicited governmental assistance for its programmes, or integrated its programmes of tribal development with governmental programmes. Most of the developmental activities, agricultural development, irrigation schemes, housing, etc., are taken up in liaison with the government, utilizing the

funds allocated under the Integrated Rural Development Programme, the MADA scheme, the Food for Work programmes, the Tribal Welfare and Rehabilitation Programme, etc. As a general rule, AWARE, through its own sources of funds, whether the Revolving fund or Corpus funds donated by donors, does not put in more than 30% of the cost of any economic project. Atleast 70% is attempted to be raised through government funds allocated for the area or from the community.

2. For all capital construction costs of building, physical facilities for the hospitals, health shelters, community Education Centres etc, AWARE raises 50% of the funds while 50% is contributed by the Government of India. The Boat Hospital and the Naidupet Community Leprosy Rehabilitation Centre have been built entirely with government assistance. Land for buildings has been the donation of the local government, the State government has donated land, for the Training Centre and Head Offices of AWARE; and the District Administration for the CHCs Zonal Offices and District Offices.

3. Totally, the State and Central Government give grant in aid of 5-6% of AWARE's total budget. This is exclusive of the tribal welfare and rural poverty alleviation programme allocations utilized in the Project areas through AWARE's intervention and facilitation.

Except for certain situations where certain government officials were in league with the landlords illegally encroaching upon the land, and other similar situations, there has been no conflict with the Government.

B. Collaboration and Conflicts with the Community

The basic philosophy of AWARE stems from its commitment (and its leader's commitment) to the Gandhian philosophy and ideal of adopting non-violent means of change to uplift the poorest and under-privileged. Though there were conflicts with rich landlords, forest contractors and other exploiting agencies when the tribals attempted to get back their land or when bonded labour was to be released, the principle of non-violence and peaceful resistance was observed. Through persuasion and judicial action, catalyzed by the Legal Cell of AWARE, the conflicts were resolved.

C. Collaboration with other Voluntary agencies

AWARE trains and inspires workers from other agencies for rural development. Rural Development workers trained at AWARE for two years have started voluntary agencies in tribal areas, on their own, in Karnataka, Kerala, Orissa, and Tamil Nadu.

FINANCIAL RESOURCES AND EXPENDITURE

The annual budget of AWARE is approximately rupees five and a half crore. Of this about 9% is spent on operating costs, towards salaries and incidental expenditure of the remaining, about 40% is spent on social programmes (including health) which is not recovered from the beneficiaries, and about 60% on economic programmes. AWARE tries to maintain its contribution in the economic programme at 30%, the rest coming from the government, the people, and the revolving fund.

The budget spending in 1984-86 has been as follows:

1. Health 4.4%
2. Economic and Agriculture Programme 59.9%
3. Social Education 12.8%
4. Community Development 5.3%
5. Release and rehabilitation of bonded labours 4.2%
6. Cottage Industries 1.2%
7. Marketing justice 1%
8. Women's Development 6.2%
9. Field staff maintenance 3.5%
10. Central Administration 1.5%

The sources of funds are as follows:

About 40% of the annual budget, i.e. approximately Rs.two crores comes from overseas agencies - the Community Aid Abroad of Australia, ECHO and NOVIB of Netherlands, and NCOS of Belgium. About 25% is in the form of credit from Banks, specifically for the projects, the Industrial Credit and Investment Corporation of India and district level government agencies. The people's contribution (as payment for services rendered) is approximately 24%, and grants from State and Central Governments account for 5-6%. The balance 5-6% comes from the Revolving Fund (loan repayments by beneficiaries of economic programmes) and income generating projects.

The AWARE leadership strongly feels that with the progressive involvement of the community in funding the project and the success of the community in maintaining the loans, the AWARE should be able to, soon, become self-sufficient, and donations from foreign agencies would no longer be required.

FACTORS IN THE SUCCESS OF THE PROJECT

1. The overwhelming factor responsible for the success of the project has been the committed and dynamic leadership provided by Mr P K S Madhavan, the founder. His vision, compassion, personal commitment to the cause and dynamism could result in massive recruitment of more than 800 committed staff, who are paid far less than staff of government and commercial organizations. In turn, these staff could create a snowballing effect of creating another 25,000 volunteer leaders in a population of about one million and create self-reliance in a population accustomed to centuries-old dependence, downtroddenness and exploitation.

2. Clearcut objective of socioeconomic betterment of the tribals and harijans, and steady unwavering progress towards this goal has been responsible for AWARE's impressive achievements. Inspite of several community influences and

pressures AWARE has been able to expand the scope of activities to include the overall community in the project areas. The commitment to equity rather than to development alone has kept AWARE focussed on the tribals and harijans who are the lowest socioeconomic group in any village or area.

3. Another strategic factor in the success is the strategy of having a prolonged (six-weeks) strenuous motivational-cum- technical training programme for all levels of functionaries to test and strengthen the commitment of trainees who aspire to work for AWARE. This has resulted in recruitment of eminently suitable candidates only, being selected; the rest drop out during the training period. Mr Madhavan himself handles most of the training.

4. The strategy of close cooperation with the Government and promoting better utilization of the government budgets rather than attempt a completely parallel functioning. This has enabled the AWARE to reach out to very large number of people and maintain the pace of socioeconomic development of the poorest of people over such a long period.

5. One of the most important basic activities of AWARE on which rests the success of community participation by the socially backward tribals and Harijans, has been, the priority for eradication of alcoholism, which crippled the whole community. Much of the empowerment has been possible through removal of this basic evil by the slow but sustained education processes initiated by AWARE leaders and organizers.

Case Study: X

MALLUR HEALTH PROJECT - COOPERATIVE HEAITH CENTRE

This project was started in 1972 as an experiment in cooperative funding of a health centre, in a village already closely knit by a successful milk cooperative.

Mr G VK Rao, who was the Development Commissioner and Special Secretary for Agricultural Production, Government of Karnataka had closely followed the success story of the Mallur Milk Cooperative of the Mallur village in Kolar district. This cooperative was being skillfully and ably managed by a local financier who provided loans at reasonable interest rates to local dairy farmers, and also started the cooperative to organize the farmers for collective marketing of the product, collective dealing for fodder purchase and other support services required (in turn to enable them to repay his loans). Mr G V K Rao, convinced the management of the St.John's Medical College of the viability of a health cooperative funded through the milk cooperative and and pursuaded them to involve their Preventive and Social Medicine Department to provide the technical base for this venture. Together with the Head of the P and SM Department of the college, Dr (Mrs) Mary Mascarenhas, Mr G V K Rao, brought together the Milk Cooperative leaders . Mr K T Narayanaswamy and Mr G Papanna, and the Bangalore Dairy to which milk was being supplied, to form a health cooperative.

Subsequently the health Cooperative has evolved far beyond the initial expectations, and the following is an account of the gradual emergence of grassroot participation of the community, not only in successfully funding their own health centre and health activities, but also in community action for health. The success of this project suggests two lessons for planners and administrators. Firstly that, a health cooperative tagged to a cooperative with a sound economic base in the community is quite likely to succeed. Secondly that, cooperatives which have already been formed for agricultural or other purposes relevant to the farmers economy can be effectively mobilized for community participation in health actions, provided that, the right leadership and strategic inputs are made. Who is the right person to provide this leadership to mobilize the cooperative, is not the question. It could be the leaders of the cooperatives wherever the leadership is strong and committed. It could be on the other hand, the primary health centre doctor, who with his leadership, can utilize the cooperatives for health actions and programmes. The crucial lesson is that a cooperative with economic relevance in the village community can be strategically mobilized for primary health care. There are currently 3.5 lakh cooperatives in the country covering nearly 95% of the villages and covering more than 50% of the rural population (Ref: Planning Commission, 1989,India's Population Policies and Perspectives). Remarkable potential exists to mobilize these economically relevant institutions for health and family welfare.

The Project was initiated in 1972 with the combined efforts of Mr G V K Rao, then the Development Commissioner and

Special Secretary to Government of Karnataka for Agricultural Production, and the Head of the Preventive and Social Medicine Department, Dr (Mrs) M M Mascarenhas who drew the cooperation and commitment of the Chairman of the Mallur Milk Cooperative, Mr K T Narayanaswamy for the Project. The Mallur Health Cooperative Centre was formally inaugurated on 19th March 1973.

THE COMMUNITY SERVED

The coverage of the Health Cooperative for curative services is extended chiefly to the member families of the Mallur Milk Cooperative, which includes about 60% of the families of Mallur Kachanahalli and Muthur villages. These families sold milk on a regular basis to the cooperative. However, for preventive and promotive health services of the project, the total population of about 7000 in these three villages is being covered. In 1973, at the start of the project the population of these three villages was about 4500.

These villages had a well established Milk Cooperative which was started in the year 1963 by the pioneering efforts of a benevolent money-lender, Mr K T Narayanaswamy supported by a socialist leader Mr G Papanna. In the sixties, when there was no organised system for providing loans to the rural public from public finances, (e.g. Bank loans, Integrated Rural Development Project loans, etc.), Mr K T Narayanaswamy was the leader in organising and financing loans to farmers for productive farm activities. Mr Papanna was a popular socialist leader of the village with a strong base among the people. This area had very low rainfall and was prone to frequent droughts which made agricultural activity a gamble. Under the circumstances,dairy activity, as a source of continuous revenue for farmers, was promoted . Individual farmers had their own limitations such as, they could not sell small quantities of milk on their own; production of high quality milk, survival and care of milch animals, and provision of quality fodder on a regular basis from the fodder dealers required a group organization and collective dealing. Mr K T Narayanaswamy organised the milk cooperative to sell the milk to the Bangalore Dairy on a regular basis at fixed prices for use in the city of Bangalore, about 40 Km away. Thus the farmer escaped the vagaries of fluctuating milk prices in the open market. Mr K T Narayanaswamy was instrumental to utilise it also to serve the purpose of a forum to solve the other problems of the farmers such as procurement of good quality fodder, servicing of loans for quality fodder maintenance of proper quality of milk as laid down by the Bangalore Dairy, etc. Thus, the milk cooperative headed by Mr K T Narayanaswamy, ensured the economic survival of most farmers in the area. In 1973, this cooperative was handling about 3000 litres of milk.

Thus the cooperative system already had a strong base in this community long before the health cooperatuive wa initiated. These villages, inspite of a relatively better income compared to most other villages, had a poor health status as witnessed by a infant mortality rate of about 104 per 1000 (study of Dr P Souri Reddy in 1978-79 , Unpublished data); in the same year the IMR in the Harijan block of Nallur village was 263 per 1000, many being due to neo-natal tetanus; maternal mortality was also quite high; prevalence of nutritional deficiency was about 30%. Proportion of eligible couples sterilized was about 30% in 1976 and crude birth rate was about 32 per 1000.

These villages are also formally being covered by the Primary Health Centre, Mallur which is about five kilometers away.

THE PROJECT: ITS BEGINNING AND OBJECTIVES

Mallur had a consistent record as a successful milk cooperative since 1963, which had grown to substantial proportions by 1969, and continued to grow thereafter. The milk was being sold to Bangalore Dairy, and thus, this cooperative care to the notice of the State and Central Governments, as one of the few successful rural cooperative ventures. The then Development Comissioner, Mr G V K Rao and the St John's Medical College were keen to demonstrate a community based, self sustaining and community financed health care set up. The success story of the Mallur Milk Cooperative, led them to approach the Chairman of the Milk Cooperative and other villag e leaders to start a health centre run by the milk cooperative, initially subsidised by the Bangalore Dairy, and gradually to be taken over completely by the cooperative. The project was envisaged to function as follows:

a) Finance

Monthly estimated expenditure of Rs.3500 on account of salaries, rent of building, etc., would be met by contribution from the Milk Cooperative of one paise for every litre of milk handled, and two paise for every litre of milk handled, from the Bangalore Dairy.

b) Technical Inputs

The St.John's Medical College would provide technical guidance for all health care activities, which were envisaged to grow from the initial curative services, to a wide range of preventive and promotive health services with the participation and increasing involvement of the community in these villages. The Department of Preventive and Social Medicine would assist in identifying suitable staff, would provide guidance to the Health Committee to develop the skills to organise the community for their increasing participation in their own health would provide referral support of their teaching hospital to tackle all complicated cases referred by the health centre doctor; organise Specialist Camps to take care of commonly prevalent health problems requiring specialised attention and skills (for example cataracts and other eye problems, complicated antenatal cases, etc.)

c. Staffing of the Health Centre

One medical officer, one compounder and one ANM were to be appointed and paid by the milk cooperative. The staff while receiving technical guidance from the St.Johns Medical College were accountable to the community in the sense that they were required to organise their activities in tune with the decisions of the Health Committee. However, the medical officer being a member of the Health Committee, was to advise, educate, and guide the Health Committee in taking realistic decisions on actions for health.

d. Control of the Health Cooperative

The Health Cooperative was to be controlled by the Health Committee which was formed originally by representatives from the Milk Cooperative, the St.John's Medical College, the Bangalore Dairy, the State Government, the Mallur Panchayat and Medical Officer of the Project.

Under these conditions the Mallur Health Cooperative Centre was formally inaugurated in a rented building in 1973.

Objectives of the Project

1) To study and devise methods by which the financial base needed for health services could emerge from the people themselves in a self-sustaining manner.

2) To train intern doctors, nurses and other medical and paramedical staff, for the purpose of rendering health services in rural areas.

3) To help in the establishment of rural health centres for provision of effectve health services to a wide circle of needy people without distinction of race, cast and creed.

4) To help in those developmental activities which are very necessary to ensure effective rendering of health services in rural areas.

The St.John's Medical College and its Department of Preventive and Social Medicine, were perform to the role of a catalytic agency in the formation of a self sustaining rural community health scheme, fulfilling the above objectives.

ACTIVITIES

The Project activities are organised towards providing free medical care to member families of the Milk Cooperative of the three villages, medical care on a paying basis for non-member families of Mallur and surrounding villages who came on their own seeking medical aid, and, preventive and promotive health services emerging as needs of the total community of the three villages as articulated by the Health Committee.

A. Personnal Services

a) Curative Clinic (daily outpatients)

b) Maternal and child health services, including antenatal care, domiciliary midwifery, postnatal care, under-fives clinics.

c) School health service for village schools - periodic check- up of school children in these villages to detect and treat nutritional, eye, dental, and other health problems at an early stage.

d) Immunisation programme on a camp basis, after due propaganda and health education has been done in the villages to motivate mothers to bring their children for immunisation.

e) TB and Leprosy case detection, treatment and follow-up case detection is done at out-patient clinic, and other weekly clinics like antenatal clinic, under-fives clinic, and camps organised for other activities.

f) Motivation for family planning - as and when contact with an eligible couple is made in the course of providing other services.

g) Specialised camps in Mallur : Eye camps to diagnose eye pathology and perform cataract operations, antenatal camp to advise, treat and if necessary refer complicated antenatal cases, etc. are conducted by specialists from the St John's Medical College.

h) Hospital referral Services: Complicated cases beyond the capacity of the health centre, are referred to the nearby Sidlaghata Taluk Hospital or the St.John's Hospital.

i) Family record maintenance: Each member family of the cooperative has a record book which is maintained at the outpatients clinic in which episodes of illness and other health data are entered.

B. Community Services

a) Guidance for protection of well water by chlorination

b) Popularisation and initiation of community efforts for construction of sanitary latrines and soakage pits, other advice on environmental sanitation.

c) Collection of health data through periodic surveys

d) Coordination and collaboration with Government Health Personnel in National Health Programme activities.

e) Health education at personal, group and village levels. Target groups are school teachers, mothers, children of middle and high school for whom child-to-child health education programmes are conducted.

f) Nutrition education to teachers, to villagers through street plays, mother's motivation programs etc.

Health education activities include regular Child-to-Child health education programmes conducted by the Health Education team of the Departments of Community Medicine of the St.John's Medical College, at the various schools in Mallur and surrounding areas. Involvement of children in health education is expected to have a wide impact, since they spread the health messages to their parents and other adults of the locality. Under the Mother's Motivation Programme, large groups of mothers are invited to the rural subcentres and they are made aware of various facets of nutrition, child care, immunization etc. Motivated mothers to be trained, are selected from several villages, through the efforts of Mahila Mandals who are contacted by the social leaders of Mallur, when the Health Committee decided to conduct the programmes.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The organizational structure that carries out the Mallur Health Project can be clasified as (i) Formal and (ii) Informal.

Formally appointed staff

One Medical Officer, one compounder, one auxillary-nurse- midwife and one accountant are stationed at the Health Centre to carry out the work. The Medical Officer is assisted by one house surgeon of the St John's Medical College who is posted for rural internship training.

Informal Organization

The work of organizing and carrying out all activities other than that carried out at the Health Centre, is done on voluntary basis by the local Health Committee Members, namely the two Gramabhivruddhi Sangha representatives, the Panchayat representatives, Youth Farmer's Association representatives, as well as the active members of the Mahila Mandals and Men's Youth Clubs of the village where the health camp is being held.

Leadership

The leadership was initially provided by the two Milk Cooperative leaders, the Chairman and Secretary Mr K T Narayana Swamy and Mr Papanna respectively, to carry the community with them in sustaining the health activities. Gradually younger leaders from the Youth Farmers Association were developed, and now, the second line leaders lead the Grama Abhivruddhi Sangha (Village Development Association) and provide leadership for developmental activities including health. Technical guidance is provided by the Department of preventive and social medicine of the St John's Medical College.

PROCESS OF COMMUNITY PARTICIPATION

The process of community participation for health, began with the decision of the top leadership of the Milk Cooperative to be partners in the creation of the Health Centre. The leaders who organised and largely controlled the economic base of most farmers of the locality, were able to carry the community with them in this decision. The farsighted, benevolent nature of the leadership was not content with merely setting up the Centre. From the beginning there was a commitment to abide by the Health Committee's decisions. The Health Cooperative leaders were committed to a policy of convincing and drawing the involvement of all other social and panhcyat leaders into the Health Committee, induct emerging younger leaders (like the Youth Farmers Association activitst etc.) into the Grama Abhivruddhi Sanga (Village Development Organization) and through that, ensure that decisions were increasingly community-based over the years.

Thus it began with a centralised village leadership participating in decision-making, and evolved into a more broad- based community involvement in planning and action.

Participation in Health Activities

i) Planning: The community leaders in the Health Committee, based on their observations of ill health in the community and discussion with Medical Officer and the St John's faculty, plans for health activities. Actual items of activity for the next month (like immunization camps, school health service, MCH and eye camps.etc.), action to be taken to contain an outbreak of an epidemic, propaganda and other activities to be done, area of operations, etc. are planned in detail.

The work and responsibility for raising supplementary funds is divided between the members.

ii) Organising and implementing the activities: After the responsibilities are apportioned, the respective members of the Health Committee contact the village Mahila Mandals, Youth Farmer's Association members, school teachers, etc, to extensively educate the community to the topic, and ensure attendance of the eligible population at the camp. The actual supportive arrangements for the camps is done by local volunteers.

iii)Supplementary fund raising :Supplementary funds required for camps for items like lunch/dinner for camp participants and the medical organizing team, other incidental expenses, etc. are raised in the form of donations or grants from the Mallur Panchayat through their representatives on the Health Committee.

iv) Maintenance of the Health Centre: The Health Committee takes decisions on all day-to-day matters relating to maintenance of the Health Centre, such as sanctioning monthly budget for drugs, decision of charges to be made for outpatient and domicilliary service expenses, repairs etc. Decisions on expansion of facilities, equipment, etc, are also taken.

v) Evaluation and feedback: So far the community has not felt the importance of evaluation and feedback on the health activities and this aspect has not received attention.

RESULTS

The results of the Community participative approach have been as follows:

A.HealthSector:

a) Generally improved health and nutrition status of the population in three villages

b) In the case of family planning, Mallur village stands first in Siddlaghata Taluk. Though the Mallur Health Cooperative does not concentrate on the Family Planning Programme, realization of the benefits of family planning by the community has resulted in a high rate of family planning acceptance.

c) Matternal mortality, diarrhoeal disease and infant mortality have declined. Diarrhoeal deaths are almost unheard of in recent times.

d) A community Hospital with modern equipment has been constructed in Mallur village with the help of individual donations, donations from the Milk Cooperative and other resources. The efforts for the Hospital were put in by the Grama Abhivruddhi Sangha after the Milk Cooperative withdrew from direct funding of the Health Centre.

B. Other Sectors

a) Almost 100% school enrolment even among the harijans, and low school drop-out rate. In addition to the government school, self financed private, primary, middle and high schools are being run in the village.

b) Piped water supply is supplied from tubewells to the entire village.

c) 50% of the village people use sanitary latrines.

SUCCESS OF COMMUNITY PARTICIPATION IN HEALTH AS A STIMULUS FOR SIMILAR EFFORTS IN OTHER SECTORS

As a result of the success of the Health Cooperative, the community has taken up other participative developmental activities as follows:

i) Education: Social leaders of the Village started private, primary,middle and high schools through mobilization of community resources. These schools are controlled by the School Committee, which appoints teachers, fixes rates of school fees, etc. The School Committees has also extended its informal influence to the Government School in the village, to ensure better performance by the teachers. The social activism of the School Committee ensures nearly 100% attendance at school by the children in the aea, including Harijan children and almost no drop-outs.

ii) Piped water supply: Potable water supply through taps from a few tubewheels to the entire community has been implemented through mobilization of community resources.

iii) Involvement of the Harijans : Although there are not many Harijan families who are members in the Milk Cooperative, the leadership of the cooperative has succeeded in bringing out leaders from the Harijans too and ensure their participation and leadership in education, environmental sanitation, etc. All the houses in the Harijan colony are pucca.

iv. Tackling of social ills such as drinking and gambling: These habits, which ruin the economic life of a village if they become a way of life, are kept to a minimum by socially ostracising those who indulge in them same and through other social sanctions.

v) Environmental Sanitation: Public latrines have been constructed through utilization of developmental funds from the Government, and personal donations from the villages. Private latrines have been popularised and constructed. About 50% of the people in Mallur, Kachanahalli and Muthur villages use sanitary latrines.

vi) Law and Order: Law and order is completely maintained and handled by the local panchayat. There has been no criminal case registered with the police in the history of the village.

CHANGES IN THE PROJECT OVER TIME

1) Change from partial funding, to total funding by the Cooperative

Initially the focus was on medical and primary preventive services from the Health Centre. The community headed by the Milk Cooperative leaders chiefly wanted quality curative services. The Health Centre, supported by effective

referral services on a free/subsidised basis by the teaching hospital of St.Hohn's Medical College at Bangalore, made the community realise the value of having an accessible health clinic under their own control. At the start of the Project, it was envisaged that the financial contribution from the Bangalore Dairy would be phased out within a period of three years, and the milk cooperative would then finance the recurring expenditure independently. However within five months of starting of the project, owing to favourable prices in the open market for milk, many members of the Milk Cooperative began to sell the milk in open market rather than through the Cooperative . This resulted in Bangalore Dairy stopping its subsidy for the Health Cooperative. At this crucial point, the Milk Cooperative took a decision of taking over the financing and control of the Health Centre fully, rather than allow it to be closed down.

2) Change from continuous Cooperative funding to a fixed source of income

Since 1985 a further change has taken place in the financing and therefore, control of the project. Owing to the boom in sericulture in the early eighties, sericulture, which was the other major agricultural activity in this area; overtook milk production in its popularity among farmers. The amount of milk handled by the Milk Cooperative declined and the influence of the Milk Cooperative over the local population declined. The leadership of the Milk Cooperative changed, and again,there was a crisis of funding for the health centre, since the Milk Cooperative under the new leadership, with reduced financial strength, decided to withdraw from the project. However, the health cooperative was spared from being closed down through the far sighted action of the milk cooperative leaders in the early eighties, who had invested a substantial amount of money (about rupees six lakhs) in fixed deposit for the Cooperative Health Centre. When the crisis came, the Village development Committee, i.e. the Grama Abhivruddhi Sangha, formerly a wing of the Milk Cooperative was authorised to take part in the control of the Health Cooperative, through its representatives nominated to Health Committee. The Health Cooperative since then, is financed by the interest received on the fixed deposit. However, several ongoing developments such as construction of a hospital, minor funding for camps, etc. continue to be undertaken by the local community through raising contributions from families, donations by the well-to-do, etc.

3) Changes in the Scope of Activity

The scope and intensity of activity has been showing changes over time, concomittantly with the changes in the source of funds and leaders controlling the project. Initially when the Health Cooperative was started, the focus of the project was chiefly on conventional health service - curative and certain obvious preventive services such as immunization. As the leaders of the milk cooperative took the decision of financing it on their own in 1975, and they were also enthusistic to promote social and economic change through education and involvement of the community, there was a high tempo of activity after 1975, up to the early eighties. When the Milk Cooperative withdrew financial support, they automatically lost the major say they had in the activities and organization of the Health Cooperative, and as a result of the tempo of activities declined. While the welfare- oriented strong leadership of community leaders such as panchayat members and others, mobilized resources for community health activities, the loss of this leadership resulted in the Health Cooperative chiefly concentrating on curative and primary preventive services, and the other community services were sporadically organised from time to time.

FINANCIALRESOURCES

1. Initially, for a short period of about 5-6 months the Health Cooperative was subsidised by the Bangalore Dairy. Soon the milk Cooperative and the St.John's Medical College took up the project which was being financed until 1985 as follows:

Source	Items of Expenditure	
	Capital	Recurring
1. Mallur Milk Cooperative	Buildings,furniture refrigerator, Health education materials	Salaries, drugs, petrol, electricity general stores
2. St.John's Medical College	Physician's and Mid wifery kit, Minor surgical equipment lab equipment, Motor Cycle (on loan through UNICE5F)	Interns" Service Specialist Services Rent and electrical charges for interns quarters
3. Government Health Services	Nil	Vaccines, Vit.A, Iron and Folic Acid Supplementation, Family Planning Devices,Surveillance of communicable diseases(through PHC Sidlaghatta) Health Education Films through Health Education Depart ment of DHS)
4 Personal Donations	Nil	Supplementary funds for lunches, other incidental expenses at camps,etc.

2. Since 1985 after the Mallur Milk Cooperative withdrew from the Health Cooperative, the funding of the Project has been as follows:

a) Recurring expenditure on account of salaries, rent of building,repairs of building, and equipment and petrol through interest of approximately Rs.6000/- per month on the fixed deposit of Rs.6,00,000/- credited against the Health Centre.

b) Expenditure on drugs met with partly from interest amount and partly from a nominal outpatient fee of Ps.0-50 per patient and a fee of Rs.15/- on conducting a home delivery, charges for any other services rendered.

c) Other items of expenditure which were being borne by St.John's Medical College on items such as specialist services, transporting the specialists to the camp site from Bangalore continue to be borne by them.

d) Supplementary funds for incidental expenses to organise the camps, health education and propagand to the surrounding villages on the eve of camps (immunization, MCH Specialist camps), travels of the Gram Abhivrudhi Sangha Leaders, etc. are met through personal donations mobilised at Health Committee meetings, Grama Abhivruddhi Sangha funds (grants from the Ministry of Social Welfare), grants from Mallur Panchayat and other appropriate sources.

COLLABORATION AND CONFLICTS

The health centre was started as a collaborative venture between a government organization (the Bangalore Dairy), the voluntary agency (St.John's Medical College) and the Milk Cooperative, through the meditation of the State Government. Subsequently even after the governmental agency withdrew from the project, collaboration, at the local level with other governmental agencies has continued.

1) The Medical Officer of Primary Health Centre, Melur is a member of the Health Committee, and attends the monthly meetings. He provides the support of the PHC staff, and their cooperation by providing the services of the area staff wherever the intensive health activities are being carried out (eg. Specialist camps). Vaccines, FP devices, etc. are supplied by Primary Health Centres of Sidlaghatta and Melur. The Melur Primary Health Centre chiefly concentrates on family planning work in these three villages. For this, the Health Cooperative Centre and the Health COmmittee members actively cooperate with the PHC Staff. By and large, there has been no conflict with the Primary Health Centre, Melur inspite of considerable overlap of functions.

ii) Collaboration exists between the Health Committee and the Government Departments such as Education Department, Social Welfare Department and others, with whose support, activities such as construction of sanitary latrines, child-to-child health education programmes, Mother's Motivation Programmes are carried out.

FACTORS IN THE SUCCESS OF THE PROJECT

A. Community Factors

1. Certain basic economic needs of the community were already satisfied and community was of relatively homogeneous nature, even prior to the start of the health project.

The economic condition in these village was good, compared with what is ordinarily seen in rural areas of developing countries. The peculiar economy

was based almost solely on dairy farming. Being a highly drought-prone area, dairy farming became the chief occupation commonly practiced by most families. Besides, the source of income in the village was of decentralised nature-majority of the families owned a few dairy animals. It is a known fact that, extreme poverty or concentration of wealth/resources in the hands of a few with others in the community receivng wages and being dependent on those who control the resources, is not generally conducive to community participation. The decentralised nature of productive resources (Milch animals) yielded an atmosphere for the evolution of community participation in development.

2. Well established cooperative system for economic activities

The existence of the milk cooperative which gained its huge strength from small contributions of milk from several farming families, made it seem a viable proposition for them to run a Health Centre on their own on a cooperative basis.

3. Leadership

The benevolent leadership of a powerful local financier of the early sixties and a popular grassroote level leader, who joined hands to develop the community was another critical factor. Mr K T Narayanaswamy motivated the local farmers and at the same time provided financial backing to improve their lot through dairy farming. He provided the loans at reasonable intrest rates to the farmers. On the one hand his own economic interest would be be served by a prosperous dairy farming village community. On the other hand, he was socially committed to develop economic conditions of the villages as a precondition to serving his own interests. As a result, the milk cooperative had been formed, to facilitate a profitable dairy entrepreneurship. He led the milk cooperative to deal with the Bangalore Dairy to ensure a fair deal to the farmers. Together with the influence of the popular leader Mr G Papanna, he used his economic influence over the farmers to carry the community with him.

4. Peculiar Nature of the Economy:

Dairy farming through well distributed in the community in terms of ownership of resources, is still, capital- intensive enough, to require the farmers to take loans for initially buying the milch animals, and subsequently for good quality fodder to maintain them. Thus the Milk Cooperative which controlled the economy carried the authority to make decisions of the community in the early years of the Project.

B. Organizational Factors

Positive Factors:

1) The success of Community Participation is partly due to the commitment of the St.John's Medical College to a strategy of community participation. This commitment led to a process by which the community gradually evolved into a state of becoming capable of planning, making decisions and implementing them for their own health. The college leadership did not succumb to the tempatation of hastily implementing a preformulated health care scheme in the community which would have made the community a passive recipient of health care.

2. The collaborating organization, being a Medical Colleg, could provide a high leavel Community Medicine Departmental leadership to the Health Committee, and technical guidance to the Medical Officer to keep up the community health and development activities. Very often, at the Primary Health Care level, in the rural areas, a medically oriented doctor, however motivated for community health, often runs into serious difficulties in terms of logistics and difficulties in organizing the community and managing within the limited resources of a Primary Health Centre. In the case of the Mallur Health Project, availability of technical support from the Department of Community Medicine, supported by the other speciality departments as and when required, enabled the Health Committees decisions to take shape in reality without floundering into logistic problems.

3. Another factor was the commitment of St.John's Medical College to maintain high standards at the health project, to serve as a model training ground for its rural health training programme for medical and nursing students and community health worker trainee.

4. Provision of a strong referral back-up of the St.Johns Medical College departments for referred cases: Free/Subsidised treatment was provided at the Medical College Hospital to cases referred by the medical officer of the Centre. This was one of the factors which weighed with the community to be committed to maintaining the Health Centre, irrespective of major wranglings, change of leadership and other disruptive influences in the Milk Cooperative. Thus, even after the Milk Cooperative withdrew from the health project in 1985 with the change of leadership, the Village Development Organization continues to actively mobilise the community for actions for health.

5. Willingness of the St.John's Medical College to participate as a technical guide only. Though the college provided a house surgeon, assistance to appoint the Medical Officer and institutional support, the College remained committed at the start of the project, that the staff would be accountable to the community only. This was one of the factors which oriented the Medical Officer to enlist community participation, rather than pleasing the sponsoring agency through target-oriented activities.

C. Organisational Constraints

A major constraint for the growth and systematisation of health care activities in the project has been, the frequent change of Medical Officers - The appointees remain in position for short periods of six months to two years and they leave as and when they find better opportunities elsewhere or secure a seat for a post-graduate course. Thus, although the process of community participation has taken root, a sustained effort on the part of the Health Centre to expand the scope of activites, for example, to systematically cover the community for al health activities, and programmes, or to extend the zone of influence to stimulate community participation in other neighbouring village communities, is not evident. Frequently, by the time the Medical Officer becomes familiar with the Centre and develops the skills to participate in the Health Committee and gain the confidence of the community, he is ready to leave. This has resulted in the scope of activities remaining more or less at the same level at which it started.

PRIMARY HEALTH CARE IN THE PROJECT AREA -SCOPE FOR FURTHER IMPROVEMENT

1. Community health interventions have hitherto been of sporadic nature. A systematic schedule needs to be laid out for carrying out various health activities in a defined popultion - example - immunization on schedule to eligible children and defined population, antenatal registration, etc.

2. There is a lack of clear-cut delireation of "Community to be served", and clear-cut health goals to be achieved in this "Community". FOr provision of curative services the member families of the milk cooperative from the "Community" are served free of cost (others are served on a paying basis). For provision of preventive and promotive services the entire community of these villages is being covered. Possibly because of funding by the Milk Cooperative, non-member families though mobilized for participation, do not receive the regionalised coverage envisaged in the concept of Primary Health Care. A systematic effort to maintain some form of surveillance and ongoing service for the non-member families needs to be maintained if the primary health care needs of the area are to be met in its true spirit.

3. Todate, there has been no provision for maintenance of data on health indicators of the community for evaluation and feedback to the collaborating/sponsoring organization to determine future course of action. A schedule of periodic surveys/surveillance through outpatient data/other methods of community surveillance guide for future actions, would add to the effectiveness of the health centre and make it a truly model primary health care centre.

Case Study: XI

MINI HEALTH CARE PROJECT-A CO-OPERATIVE RURAL HEALTH SERVICE SCHEME

The Mini Health Centre Project of the Voluntary Health Services, based at the MAC Institute of Community Health in Madras, has its beginnings in the co-operative urban health plan initiated by VHS in 1958, for residents of urban South Madras. The guiding principle was to provide a largely community financed graded system of medical care namely, basic affordable care for minor ailments at the peripheral clinic level located near the homes of the people , and whenever necessary, the most sophisticated medical care to be available even for the poorest member of the co-operative. An annual family contribution, assessed on a sliding scale according to income was collected for financing the scheme. Based on the success of this scheme, the Mini Health Centre Project for the rural areas nearby was conceived, expecting only one third of the recurring expenditure to be raised from the community.

The following gives an account of the success of this cooperative model of community participation in health care, in a rural setting, as well as the leadership factors which influenced its success. The experiences of several other voluntary agencies in trying to implement similar schemes suggest that, perhaps it was the leadership factor and strong organizational base of a committed referral hospital which influenced the success of the scheme in the case of the VHS project. These experiences also suggest that, possibly, given the present socio-economic conditions of our villages, and low priority for health, a health co-operative purely for health care, based on a prepaid family premium would have limited success in sustaining for long.

Several factors are possibly responsible for this limitation of a purely health based co-operative. Firstly, the external agency seeks the involvement of the families as separate units and not as a group commitment by the total community. This results in the agency needing to keep up efforts to enlist and maintain involvement on a family-by-family basis, year after year, which can exhaust primarily health care oriented organizations. Secondly, health is not a priority of the poor who are the chief target sought to be covered by the co-operative. Prepayment for future health and medical benefits would definitely be a far lower priority than the immediate needs which they are struggling to satisfy. Thirdly, since the pure health co-operative does not carry any economic implications or economic organizing force behind it, it is difficult to sustain the commitment of families to continue in the scheme. Nevertheless, the following account illustrates the nature of participation of the community in the co-operative scheme and the remarkable changes in health status which could be brought about by a committed leadership and an innovatively designed health organization in a a rural setting.

THE COMMUNITY SERVED

The community served by the Mini Health Centre (MHC) scheme has increased from 80,000 population in and around South Madras in 1968, (80% in the rural area and 20% in the adjoining urban area) to a population of 1,60,000

mostly in the rural areas around Madras. The population was like any other poor community of Tamil Nadu. People of all socio-economic groups in the area are covered for preventive and curative services on the basis of family contributions for the running of the services.

THE PROJECT : PHILOSOPHY, BEGINNING AND OBJECTIVES

Dr. K S Sanjivi who was a Professor of Medicine at the Madras Medical College, towards the end of his long tenure, became increasingly concerned about how to integrate preventive and curative service, delivered on a community and family basis, as compared with the existing curative-drug-individual-orientation of the existing medical services. It was begun in 1958 as a Voluntary Health Scheme for residents of South Madras based on a voluntary subscription, assessed on a sliding scale in relation to family income. This system entitled subscribers to preventive and curative care at the nearest VHS Regional Health Centre, and, whenever necessary, for sophisticated hospital care at the VHS Medical Centre. This scheme became operational in Adyar region of Southern Madras City. With the success of this scheme and the growing concern of the VHS leadership for the underprivileged, underserved rural population, the Mini Health Centre Project, based on the same principles was launched in 1968 in a rural community of approximately 80,000, to be served by eight rural MHCs and two urban MHCs. The referral needs for secondary and tertiary health care could be met by the already existing sophisticated VHS Medical Centre.

The project for the Mini Health Centre Scheme incorporates the same three fundamental principles of the health plan conceived for residents of Adyar (urban South Madras) when it was initiated in 1958. These principles were sought to be incorporated at every stage of the health activity :

1. Prevention should be emphasized as much as cure.

2. Family should be the Unit for Medical Care.

3. Community participation should be ensured.

The objectives were as follows :

(i) To provide a reasonable level of Primary Health Care to all members of the community irrespective of their economic status or geographic domicile.

(ii) Provision of comprehensive, continuous, co-operative community care at the doorstep of the family.

(iii)Immediate attention to the household where the problem arises.

(iv) Services to be carried out by functionaries who reside in the community which they serve, and have received an orientation within their capacity to learn.

(v) Provision of referral services through a referral hospital and higher echelons of health services.

EVOLUTION OF THE PROJECT AND PROCESS OF PROJECT IMPLEMENTATION

In the early years a two-tier system of health care in urban South Madras was evolved as follows :

Subscribers were entitled to preventive and curative care at the VHS Regional health centres. Each Health Centre had a part- time medical officer, full-time nutrition worker, administrative assistant, a laboratory worker, and a public health worker. Upon referral, complete care including super specialities were available to subscribers at the Medical Centre.

Following the success of the venture in the urban area, ten Mini Health Centres were setup, eight rural and two urban in St.Thomas Mount community development block, adjacent to the Adyar area of the Madras City. The same staff pattern was maintained and each centre catered to a population of approximately 10,000. Each health centre was expected to carry out periodic medical examination for every family, maternal services including antenatal and postnatal care, child welfare services, school health, family welfare and planning, medical care for tuberculosis and leprosy, screening for preventive diseases like diabetes, hypertension etc. For this, the population of 10,000 proved unwieldy and services were not satisfactory. So the staff pattern of the MHC was modified to provide primary health care by three levels of health functionaries.

At the village level, a Lay First Aider (LFA), in charge of a health post, looks after the health needs of approximately 200 families (a population of 1,000). She lives within the community, is available at all times, all 24 hours, has completed atleast eighth class and is given appropriate preventive health service training at the MAC Institute of Community Health (attached to VHS).

At the MHC level, the Multi Purpose Workers (both male and female workers) are available at the MHC on all days of the week to provide treatment for simple ailments, basic MCH and FP services and assisting the medical officer to conduct the clinic during his visit.

The LFA gives treatment to the patient for maximum of two days on payment of a fee of 25 paise, which is collected in a hundi box with two slots, one for putting in the coin and another for a form giving particulars of the patients, symptoms and the medicine given. The forms and cash collections are handed over to the male health supervisors, each of whom oversees and provides guidance to four MHCs in all activities.

The medical officer is part time, attending the MHC thrice a week for about three hours in a day. The M.O. treats patients reporting at the MHC or referred by the LFA, scrutinizes and coordinates record maintenance (vital events, family health, tuberculosis, leprosy, family planning, and other records), provides antenatal and under-five care of complicated cases, and in general, monitors the health of the 5,000 population covered by the MHC. Complicated antenatal cases, medical and surgical cases requiring referral hospital attention, are referred by him to the VHS health centre. The medical officer is a person commuting from a neighbouring urban or semi-urban area who is already practicing in his area, and motivated to do some work for community health in addition to his usual practice. He is trained by the VHS in the running Mini Health Centre. He is paid an honorarium of Rs.300 per month for part time services. The

multipurpose worker male and female are full time and paid Rs.400 per month each, and the LFAs are paid Rs. 50 per month.

While the medical officer chiefly looks after the technical aspects of the MHCs, the social organization and community contacts for health and community participation aspects is the responsibility of the LFAs and the multi purpose workers. Administration, guidance for field work, supervision and control for the maternal and child health, family planning and other activities, is the responsibility of male and female health supervisors, each one supervising four MHCs in their charge. By making intensive visits to the MHCs they are in close touch with atleast 10% of the families in their area. They look after the community involvement aspects in their area through organization of action committees and health education meetings with the village leaders, to evoke responsibility, for public health and environmental sanitation actions. The female supervisor on account of her experience is able to provide supervision and guidance to the MPWs in screening out high risk antenatal and postnatal cases, and undernourished and 'at risk' children. The females MPW along with the help of the female supervisor identifies women leaders in each village to be trained as LFAs.

ACTIVITIES

The project is essentially a demonstration-cum-service project to provide comprehensive health care in a typical rural and urban population on a co-operative basis, keeping in view the constraints of expensive urban-based medical manpower and low community affordability for health care. The project provides services on this basis within the project area, and at the same time, seeks to evolve continuously towards a more and more replicable model which can be popularized and implemented throughout the State and eventually the rest of the country, through the Government and voluntary agencies.

The Mini Health Centre Project concentrates chiefly on health activities. In the process, if community organization for health-related economic and other activities emerge as a felt need, then liaison work is done with the appropriate departments by the peripheral health workers. The activities under the Mini Health Centre Project are as follows :

A.Provision of Primary Health Care to the Community :

(1) Medical Examination of every family and maintenance of health records.

(2) Maternal services including antenatal and postnatal care, screening for high risk cases and referral if necessary to the VHS Medical Centre.

(3) Child Welfare Services : Maintenance of growth cards, immunization, nutritional assessment and treatment of undernourished children.

(i) Health education and motivation by the LFA in the community for health and nutrition practices, immunization acceptance, need for underfives growth monitoring among mothers.

(ii) Growth monitoring of children, nutritional assessment, maintenance of growth cards, immunization services by MPWs.

(iii) Care of undernourished and ill children by the medical officer.

(4) School health - mostly conducted by the medical officer.

(5) Family welfare and family planning -

(i) Motivation of mothers by the LFA

(ii) Family planning services by the multi purpose workers and the medical officer.

(6) Medical care including domiciliary treatment of tuberculosis and leprosy - provided at the health centre level.

(7) Laboratory investigation - Screening for the disease such as diabetes and hypertension at the health centre level, and community education to undergo these tests periodically, especially in the high risk group, by the LFA.

(8) Treatment of Medical Ailments :

(i) Short duration treatment of two days for the ten common symptoms by the LFA or MPW.

(ii) Treatment of certain illnesses by the medical officer and referral

(9) Collection of feedback information through weekly reports from LFAs and monthly reports from the doctor and multipurpose workers. These are analysed and researched at the VHS - MAC Community Health Institute to maintain the Mini Health Centre services responsive to the communities' changing health needs.

B.Raising funds on a Co-operative basis :

Administration is a major activity, to maintain as far as possible, a level of one-third financial contribution by the community, that is, approximately Rs.10,000. This is collected through collection of minimum of Rs.12 per family per year for families earning less than Rs.200 per month, and a maximum of Rs.300 annually, from families earning more than Rs.2500. The LFAs, the health supervisors-male and female, and the multipurpose health workers, through their contact with the community in their respective capacities, attempt to enroll subscribers and ensure continuing payments. In addition, a fee for service is charged ranging from 25 paise charged by the LFA for treatment of minor ailments, to a suitable nominal fee for curative services provided at the Health Centre and VHS Medical Centre. (Rs.1 for medicine and Rs.2 for injection). This is charged in addition to the annual membership fee, in order to avoid misuse of the curative facility.

C. Training for the purpose of manning the MHCs :

The following training programmes are conducted by the VHS

(i) 18 months for multipurpose health workers (MPWs)

(ii) Six months adhoc course for multipurpose workers

(iii) Training of LFAs and Medical Officers

(iv) Other need-based training.

D. Research Activities :

Collection of systematic data, monitoring and analysis of data to assess the performance of the MHC system in the different health programmes. Data collection is emphasized from the LFA level onwards from which the data is generated, delivered to the MPWs, checked for quality by the health supervisors and transmitted to the Project level at VHS for analysis.

E. Gathering of information on local beliefs and practices (ethnomedical practices) for instance, use of neem leaves and other indigenous medicines, in order to study how traditional medicine could be integrated into modern community health. Some of the beliefs are being tested through scientific studies undertaken by the MAC institute of community health and Dr. A Lakshmipathi Unit for Research in Indian Medicine, a unit attached to VHS.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

A. Leadership :

The leadership to the organization has been provided by Dr. K S Sanjivi. After retirement from Government services he was determined to operationalise a prepaid health insurance cooperative system, partly supported by government, which would ensure the availability of even tertiary level of health care to the poorest village; covered by the scheme. In the difficult milieu of rural India, where paying in advance for preventive health services is certainly not a part of the culture, the leadership of Dr Sanjivi in drawing committed people from the health profession and the community to operationalise this system, is indeed notable.

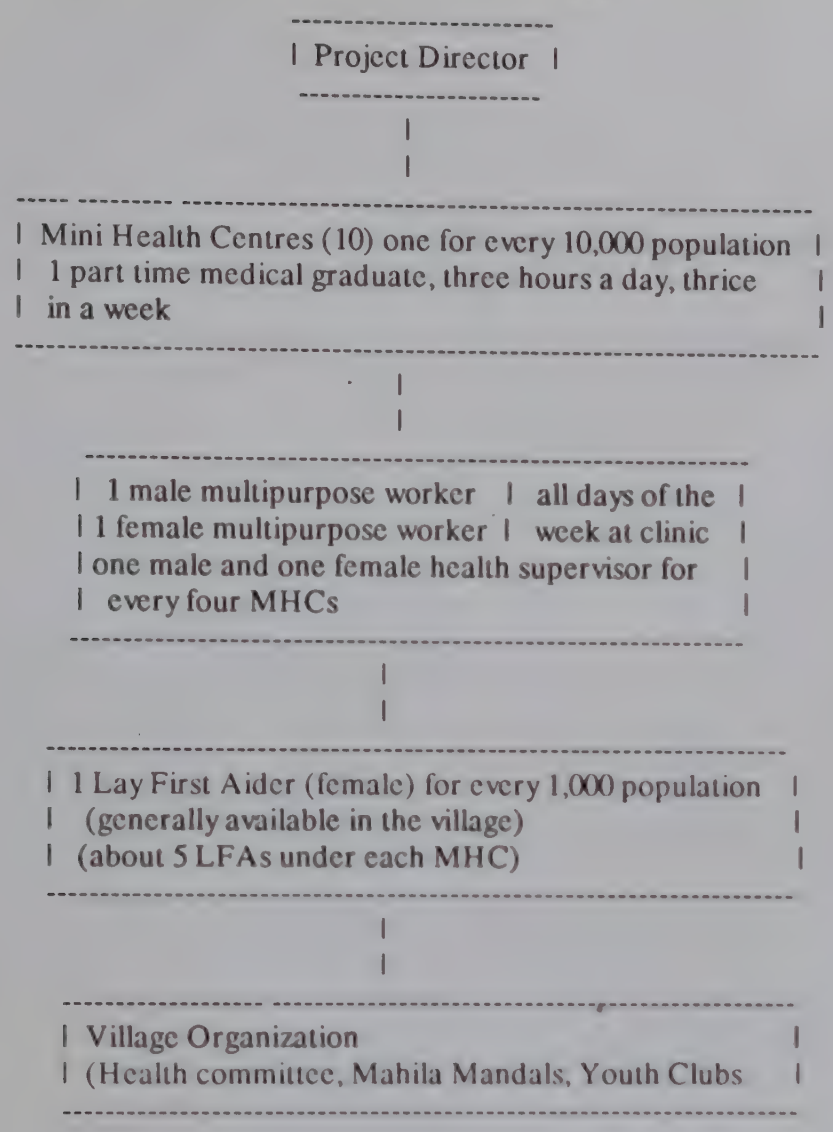
B. Organizational Structure :

Today the organizational structure of the Mini Health Centre project is as follows :

The LFAs are women, preferably middle aged who have completed eighth standard, with leadership qualities, selected by the female MPWs of the MHC, and given adequate training.

MPWs both male and female are candidates who have passed or failed in SSLC and suitably trained by Government or voluntary agencies as multipurpose workers. In addition, if necessary, an adhoc training of six months is given by the VHS. The part time medical officers are practitioners in the nearby urban or semi- urban areas who are motivated for community health, and trained by the VHS to organize the activities.

Structure of the Organization



The referral services are provided by the VHS Medical Centre where eight full time medical officers, and superspecialities including neurosurgeons, cardiologists are available for tertiary level health care not only for the MHC Project area, but also for citizens of urban Madras.

The Mini Health Centre reports are collected, monitored and evaluated by the suitably staffed Department of Community Health of the VHS and the MAC Institute of Community Health which provides the research support services for the further evolution of the proposed, to be popularised throughout the country.

In addition to the top level leadership and vision provided by Dr. K S Sanjivi, a motivated and capable second line leadership in Dr. Venkateswara Rao and other staff has been developed, who have every confidence and vision of operationalising this cooperative health scheme throughout the country.

PROCESS OF COMMUNITY PARTICIPATION

The following features have to be borne in mind while considering community participation in the MHC project.

(i) The thrust of the project remains health and the leadership strongly believes that the health staff and the scheme should remain focussed on health. Even though many related sectors do have an impact on health, such as income generation and agriculture, the health project does not diversify for fear of diluting the efforts.

(ii) Although community participation in the form of partial support of the health programe is a must for meaningful delivery and utilization of health services, in the present situation, community alone cannot bear the entire cost and government will have to subsidise the system substantially.

The community in the project area participates in the following ways :

1.Financial support

(i) About 60% of the families in the VHS project area pay the contribution ranging from Rs. 12 per family per annum to Rs. 300 per family per annum, (.5% of the joint family income), towards preventive and curative health services provided by the Mini Health Centre and Referral Hospital.

(ii) The community while availing curative services pays a fee of 25 paise to the LFA, and, at the health centre Rs. 1 for medicine and Rs. 2 for injections.

2.At the time of implementation, the community provided the building and furniture for the MHCs; besides, the actual location of the Centre is decided through the Village Health Committee which is initiated by the male MPW of the community and the health supervisor. However, involvement of the community and its leaders in planning the health services is still minimal.

3.The community has utilized the health services provided to such an extent that remarkable improvements in health status is evident.

4. Mahila mandals, Youth clubs and Village committees which are stimulated by the LFAs, MPWs and the health supervisors are active in mobilizing public opinion for participation in MCH and family planning programmes.

5. In every village four to five women who are suitable to be trained as health workers came forward to be trained as Lay First Aiders (LFAs) and subsequently, they work in the community being paid a very nominal honorarium of Rs. 50 per month.

However, it should be noted that in most other areas where the mini health centre scheme was adopted by the other voluntary agencies, the communities share of 1/3 of the recurring cost which was envisaged by the Government of Tamil Nadu, has not been forthcoming, and mostly, the voluntary agencies themselves are contributing this one-third share of the fund from other sources.

COLLABORATION AND CONFLICTS

A.Collaboration with the Government

The Government of Tamil Nadu started supporting the project since 1970, in order to bring out a suitable system of cooperative health care which could be initiated by the umpteen voluntary agencies operating in Tamil Nadu. Since the inception of the scheme, the Government of Tamil Nadu has contributed a sum of Rs. 30,000 towards capital expenditures and a sum of Rs.90,000 for recurring expenditure per year (which works out to Rs.9,000 per mini health centre - one-third the cost of running the health centre). Subsequently the Government of Tamil Nadu has adopted this scheme, for financial assistance to voluntary agencies. Since 1977, 50% of the expenditure is guaranteed by the Tamil Nadu Government to any voluntary agency, which implemented the mini health centre scheme and which undertook to supplement the remaining 50% ,either by raising money from the community or by subsidising the shortfall from its donors. Currently, the average cost of Rs.27,000 of running a Mini Health Centre is being shared in the ratio of 1:1:1 by the Central Government, State Government and the Voluntary agency concerned.

The developments speak of the ability of the leadership of the project to draw the Government into a permanent commitment to partially fund the scheme.

The Government of Tamil Nadu has recognized the Voluntary Health Services Institute of Community Health as a training centre for training of Diplomats of the National Board of Community Health), and training of multipurpose workers.

Generally, there has been no conflict with the community.

B.Collaboration with the other voluntary agencies

VHS trains multi-purpose workers for other voluntary agencies in the country.

VHS provides practical guidance to the other voluntary agencies to organize the Mini Health Centre Scheme in their project areas.

RESULTS

The achievements of the VHS project have been as follows :

The results have been evaluated in the area of health in the project population of about 1.6 lakhs.

(i) Between 1977 and 1986,the crude death rate has gone down by 50%

(ii) The crude birth rate has gone down by about 39%

(iii) Infant mortality has been lowered by 35%

(iv) Antenatal registration in the project area approximates 94%, and four fifths of the registered pregnant women received antenatal care. 40% of all deliveries are conducted by trained health workers and 90% of mothers receive postnatal care. This has been achieved against a background picture of 92% of deliveries conducted by untrained midwives (dais) in 1977.

(v) From an immunization coverage of less than 2% in 1977, the immunization coverage with full protection in 1986 was more than 50%. Regular child care services are able to reach 80% of the children.

(vi) The leprosy and tuberculosis picture has undergone marked change. From a stage of almost nil case detection and treatment, the full potential of case detection and treatment has been reached.

(vii) A wealth of information on ethnomedical practices has been gathered through LFAs, as a result of which, marked progress is expected shortly in the area of integrating traditional medical practices with modern medicine towards a viable and acceptable health care system.

Encouraged by the success of the MHC experiment, 93 voluntary agencies in Tamil Nadu State have started MHCs and are managing about 300 MHCs covering a population of about 1.5 million.

FINANCIALRESOURCES

Initially the project was begun with a grant from OXFAM for the pilot phase for evolving a community health project. Subsequently when the project was formally launched, the Tamil Nadu government came forward with capital expenditure of Rs.30,000 annually, and recurring expenditure of Rs.90,000 per year (at the rate of Rs.9,000 per MHC per year towards staff salaries, etc.). Local funds to the tune of Rs.10,000 have been raised per year from the community of each MHC through prepaid insurance contribution and fee for services.

Vaccines, family planning supplies and nutritional supplements are provided free of cost by the government.

While this is the status of financing of the MHCs in the project areas of the VHS, in the case of MHC projects run by the other 93 voluntary agencies, hardly any funds are raised from the community and the one third share which the voluntary agencies have to contribute to match the 2/3 from the State and Central Governments, is being met by grants and other sources of income of the voluntary agencies, and very little is raised from the community.

FACTORS IN THE SUCCESS OF THE PROJECT

The success of the VHS health project has to be viewed from two angles, one is, the success story of health being successfully delivered through a system of Lay First Aiders as the first point of contact between the community and the health care system. The other aspect is the success of a prepaid insurance system of cooperative health care, in a community accustomed to receiving health care free of cost from the government, and with a deep seated tradition among both health staff and the community, that health and medical services are the domain of doctors and para medical workers. Success, from both these view points has entailed overcoming resistance to change. The factors which have enabled a change in the community attitudes and health practices can be identified as follows :

1. The visionary leadership and commitment of Dr. K S Sanjivi who pressed forward in the community to gain their support and participation in the cooperative health system after being convinced that a prepaid insurance scheme is definitely a viable way of providing health services, which also ensures the community's participation and demand on the health services.

2. Again, it is the leadership factor which was important for vigorous implementation of the health services, such that an impact on birth and death rates and such other major health indicators could be made.

3. A strong referral back-up could be provided by the VHS Medical Centre to provide secondary and tertiary levels of care which was built up even before the project began, and this was also a major factor in gaining credibility and acceptance by the people for this scheme.

4. The strategy of having trained community health volunteers - the lay first aider to prepare the community for a change in their health practices, was a major factor in the success of the project.

LEARNINGS FROM THE PROJECT

1. The experiences of the Project leader and staff in the task of enrolling people and sustaining the participation in a cooperative prepaid health insurance scheme, has a lesson that, uprooting the traditional resistance of the community to prepay for health services is a very difficult task. Even today, maintaining the community's contribution at a level of about 60% of the families paying their annual contributions, is an up-hill task for its health staff and LFAs. For them it is an ongoing continous effort to raise these funds. In the project areas of other voluntary agencies who have taken up the MHC project for implementation, the community contribution is very low, and the MHC system instead of functioning as a cooperative system, functions as a externally supported health system, with the additional input of management by the voluntary agency rather than management by the Government.

2. Again, the success of the VHS as compared with the inability of many other voluntary agencies to induce community acceptance of the cooperative system, points to leadership as the chief variable for implementation of any programme.

Case Study : XII

K E M HOSPITAL PROJECT - VADU RURAL HEALTH PROJECT

This project was started by Kind Edward Memorial Hospital of Pune, headed by Dr(Mrs) Banoo J Koyaji, with a view to develop a system of comprehensive primary health care with community participation, within the framework of existing primary health care policies, utilizing the existing staff pattern of government professionals and para professionals posted in the rural areas. KEM Hospital started as a small 25-bed maternity hospital which grew to a 450 bed teaching hospital under the leadership of Dr Coyaji. In 1972, the Vadu Medical Centre was started out of a concern that, inspite of sophisticated medical services being available at Pune, the health and mortality conditions in the villagers continued to be disamal. After considerable experimentation they evolved the system of utilizing the services of trained village health guides as the means to enlist community acceptance of outreach services, as well as participation for health. The major focus of the health programme was maternal and child health care. To the health programmes, the component of socioeconomic development was also added. The activities of the Project have gradually been changing the health and socioeconomic status of the villagers. The following gives an account of the Project.

BACKGROUND

The community served originally consisted of a population of about 30000 in 19 villages of Vadu block of Pune district, about 30 kms from Pune. Subsequently, the Project has been expanded to cover a population of 1,50,000 in 70 villages spread over three blocks of the district. The area is drought-prone with poor agricultural productivity and few scattered small industries. Health status of the people was similar to that of any poor rural area. The infant mortality rate was about 118 per thousand live births; crude death rate was 10.4 per thousand, maternal and child care was of a very low order. Incidence of communicable diseases was high. The slide positivity rate was 7.4% during the first year of the Project.

THE PROJECT: BEGINNING AND OBJECTIVES

In 1972, Dr Banoo J Coyaji, Head of the KEM Hospital started a medical centre in Vadu to provide basic curative facilities to the villagers. Gradually the shortcomings of the clinic-based approach became evident . This resulted in planning for promotive services at the village and family level together with provision of referral services. A viable organization through which these services could be provided, evolved gradually and with this the objectives of the project took shape. Subsequently, following the establishment of the United Socioeconomic Development and Research Programme of which Dr Coyaji was also a founder, the socioeconomic development programmes were also integrated with the health programme. The objectives of the Project are as follows:

1 To develop a system of comprehensive primary health care with full community participation.

2. To assess the replicability of the model

3. To use socioeconomic programmes as an entry point for improving programme acceptability.

NATURE OF THE PROJECT AND PROJECT IMPLEMENTATION

A. Nature of the Project

The thrust areas of the Project are in line with the government directives and policies namely -- maternal and child health, family planning, control of communicable diseases, health education, environmental sanitation, and socioeconomic programmes.

B. Process of Project Implementation

Following the experiences of the Medical Centre at Vadu, the KEM Hospital leadership decided to implement a comprehensive health care programme in collaboration with the government and local bodies. In 1973, a tripartite agreement was made between the State Government of Maharashtra and KEM Hospital, by which, the technical and administrative control of Primary Health Centre, Vadu block was handed over to KEM Hospital, which was entrusted with the implementation of the government programmes and other additional health inputs in the block.

In 1977, a scheme of training local motivated persons from each village, as community health guides was launched. They were to act as the interface between the regular health infrastructure and the community, and to educate and motivate the community to accept and participate in the health and family planning services.

On the one hand, the Primary Health Centre staff and multipurpose workers of the subcentres, recruited and posted by the government, were reoriented and guided by the KEM Project leaders. At the same time the Project leaders established contacts with the community, selected suitable persons of the village-one male and one female worker, and trained them at the KEM for three weeks to provide primary health care services, and to become change agents to motivate the community to participate in the programmes.

The community health guides are responsible to make the community aware of their health needs, to create self reliance and to help the community to fully utilize the services provided. The CHGs educate the community on minor ailments, health matters including TB, leprosy, water-borne diseases, mother and child care, oral rehydration therapy, immunization, family planning, environmental sanitation and hand flush latrines. The CHGs also treat minor symptoms as well as provide oral rehydration therapy and treat minor wounds and injuries.

The work of multipurpose workers is facilitated by the activities of the CHGs as mentioned above. The MPWs carry out their function as per the government directives. These include treatment of minor ailments, registration of vital events, registration of vulnerable groups for special care at the camps,-- namely antenatal mothers, newborn and underfives, screening of high risk mothers and children, growth monitoring of underfives, motivation of eligible couples for

family planning, distribution of conventional contraceptives, etc. The high risk mothers and children are referred to the Primary Health Centre or the MCH camp held once in about eight weeks at every village, by a team of an obstetrician, a paeditrician, a nutritionist and social worker of KEM Hospital. Otherwise for most of the normal pregnancies, and nutritional surveillance of the children, the female MPW takes the responsibility aided by the facilitation and assistance of the CHGs.

The referral services have been particularly well developed. While almost every one covered by the Project receives primary care, when need arises, the most sophisticated tertiary level specialist services are provided at the KEM Hospital. For curative services, the KEM Hospital charges a fee, commensurate with the paying capacity, sometimes waiving it in case of inability to pay. To serve the first level referral needs, the Vadu Primary Health Centre was upgraded to a 30-bed facility with operating theatre facilities.

Mahila Mandals have been activated in the Project area and with the assistance of the CHGs, they are active in translating the health and nutrition concepts into practice through demonstrations, linking health activities with cultural and religious celebrations, etc.

A special programme introduced by KEM is, rehabilitation programme for handicapped children to identify speech, eye, mental handicaps, etc, to rehabilitate them for the best possible quality of life and self reliance.

Surveillance, case detection, treatment and follow-up for the major communicable diseases, TB,leprosy, malaria and diarrhoea are carried out, and control programmes are being effectively implemented.

In addition, KEM Hospital conducts specialist clinics and camps such as cataract camps, ENT camps, psychiatric clinics, diagnostic camps to identify childhood handicaps, etc.

The environmental sanitation programme has resulted in availability of safe drinking water. However, other aspects such as, construction of sanitary latrines, soakage pits, etc. have not progressed as desired due to resource constraints. Following the establishment of links with the UNDARP, funds and organizational inputs are now better available for these and socioeconomic programmes.

The socioeconomic programmes being implemented include income generating schemes such as oil mills, organizing papad making units, enabling the women to set up tailoring units , gobar gas plants, kitchen gardens, etc. An educational component has also been added, particularly non-formal education for women to make them aware and self-reliant for the health needs of the community.

PROCESS OF COMMUNITY PARTICIPATION

Community participation as emerged of the Vadu Project was a slow process. It evolved through various stages.

1. *Seeking Cooperation of the Community:* It was clear to the leaders of the Project that the involvement of the rural poor was absolutely necessary if health care was to be reached out to every family in the area. The villagers were very suspicious and did not believe that an external agency was interested in their

well-being. To overcome this resistance and to win the confidence of the villagers, a huge meeting was called in right royal village style, where the scheme was explained by the Health Secretary, Government of Maharashtra, the President of the Zilla Parishad and the KEM staff, and then only the process of implementing the project was started.

2. *Identification of Volunteers from the Community:* The villagers were requested to recommend women and men, who they thought were suitable for the envisaged part-time voluntary work.

3. *Monthly Meetings to assess the Felt Needs of the Community:* Monthly meetings were held by rotation in different villages which were attended by the health workers, the villagers and the Project Staff. It was at these meetings that the community realised its real needs and priorities, and it was this experience which eventually made the community to participate in activities for health and development.

4. *Community Initiative:* Once the felt needs of the community were realised, the community came forward to mobilize resources. The villagers wanted a facility for curative services. The village panchayat vacated its office building and handed it over to the Project for setting up a Primary Health Care Unit. The community helped to build a four room doctor's quarters at a cost (to the hospital) of only Rs.10,000/- since the villagers provided some material and labour. When it was decided to expand the Centre into a Rural Hospital, they donated land. Even the water supply for these services has been partly provided by them.

5. *Establishment of Proximal Health Posts:* With these initial steps in community participation the community was now coming forth for starting proximal health posts by providing free accommodation.

Even so, beyond this phase of community participation, there is a long way to go to have total community involvement to plan and take actions for their own health.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The Vadu Rural Health Project grew from a small outreach centre to its present state under the dynamic leadership of Dr Banoo J Coyaji, the Director of KEM Hospital and also the Project

Director, of Pune. In addition, the leadership is provided by Dr V N Rao, who is the Director of Research at the KEM Hospital and Dr N K Kulkarni who is the Director of Community Medicine.

The organizational structure of the Project is shown in Appendix I.

RESULTS

The Project has demonstrated a substantial change in the status of the maternal and child health. Infant mortality has declined from 118/1000 to 63/1000 by 1987 primarily due to fall in post neonatal mortality as a result of child health services. However, the continuing high perinatal and neonatal

mortality have prompted a focus on safe delivery practices and provision of presterilized delivery kits.

The crude death rate had declined from 10.4 per 1000 in the 1978 to 7.8 in 1987. Nutritional status of mothers and children in the area is much better than in similar villages outside the Project area which is evident even at a casual glance.

The family planning acceptance was fairly high being about 41% among eligible couples in 1984. However, as in the rest of the country, most of these tended to be sterilizations of women past their peak fertility. Not much use of birth spacing or birth post poning methods is evident. The approach has been modified since 1984. The crude birth rate in 1987 was about 32 in 1984 and 28.5 in 1987 which does show a substantial progress. The major achievements of the Project are summarised in Table 1 and 2.

Table -1

Indicator	Level			
	1978	1981	1984	1987
Contraception Prevalence Rate (Sterilizations and IUDs	32.6	35.0	40.7	48.4
Registered Antenatal Cases (% of eligibles)	60.3	71.9	91.3	97.5
Antenatal cases fully immunized against (Tetanus	45.0	35.5	66.1	62.4
Deliveries conducted at Home(%)	N.A.	81.10	85.5	77.8
Home deliveries conducted by trained persons	N.A	. 10.6	12.3	13.7
Use of sterilized delivery packs in home deliveries (%)	N.A	.58.0	80.0	70.1
Children fully immunized against polio (%)	N.A	49.7	35.3	74.4
Children immunized with BCG (% of eligibles)	N.A.	36.6	51.5	36.3
Slide Positivity Rate for Malaria(%)	7.4	1.5	1.7	0.4

Table-2

PROGRAMME IMPACT

Indicator	Level			
	1978	1981	1984	1987
Crude Birth Rate per 1000 population	N.A.	32.2	32.0	28.5
Crude Death Rate per 1000 population	10.4	9.4	8.8	7.8
Infant Mortality Rate per 1000 live births	118.4	76.9	72.3	63.0

On the socioeconomic front, there is a great deal of change in the quality of life. The Vadu Project has a total of 98 community borewells ranging from four to nine per village. About 200 latrines have been built and the popularity of these is increasing.

By 1984, 205 gobar gas plants have been established, smokeless chulhas have been popularised; animal husbandry, village cottage industries such as condiment making, papad making, etc have been increasing the villagers involved. These activities are aided by loans, seed capital and technical expertise provided by UNDARP.

Mahila Mandals are well established in fourteen villages covering a range of activities to improve women's income, such as processing of pulses, saving schemes, lotteries, sewing classes, and a cooperative credit society.

FINANCIALRESOURCES

The financial resources for the project are mainly Government grants received for running the Vadu Health Centre and the Community Health Guide Scheme. Although Vadu Rural Hospital has been recognised as a Rural Hospital servicing the Primary Health Centres within its outreach, Government grants have still not been received. The Rural Hospital is at present run by KEM Hospital from its own grants. Fee-for-service is being collected at Vadu Health Centre and Vadu Rural Hospital from patients who are willing to pay. This is utilized for improving the quality of services.

Under the Private Voluntary Organizations for Health (PVOH) Scheme, funded by Government of India and USAID, health and nonformal community education have been started since April 1987. KEM Hospital also spends additional funds from its own sources to provide better health care facilities such as mobile units, ophthalmic services, and other specialist services.

Another voluntary agency called United Socio Economic Development and Research Programme (UNDARP) also provides funds to the area through loans, seed capital, technical inputs for economic development.

LEARNINGS FROM THE PROJECT

The experiences of KEM as a voluntary agency with responsibility for running a health programme within Governmental specifications, have provided some useful lessons.

1. The Vadu Project has demonstrated that with very few additional inputs, a health programme that conforms to Government guidelines and policies can produce significant change in health status, provided the staff are provided the right type of leadership.

2. With a proper identification and training of community based workers namely the community health guides, support, ongoing supervision and continuing education to them, substantial change in health status and participation of the community in can be achieved.

APPENDIX - I

ORGANIZATIONALSTRUCTUREOFVADURURALHEALTHPROJECT

PROJECT DIRECTOR

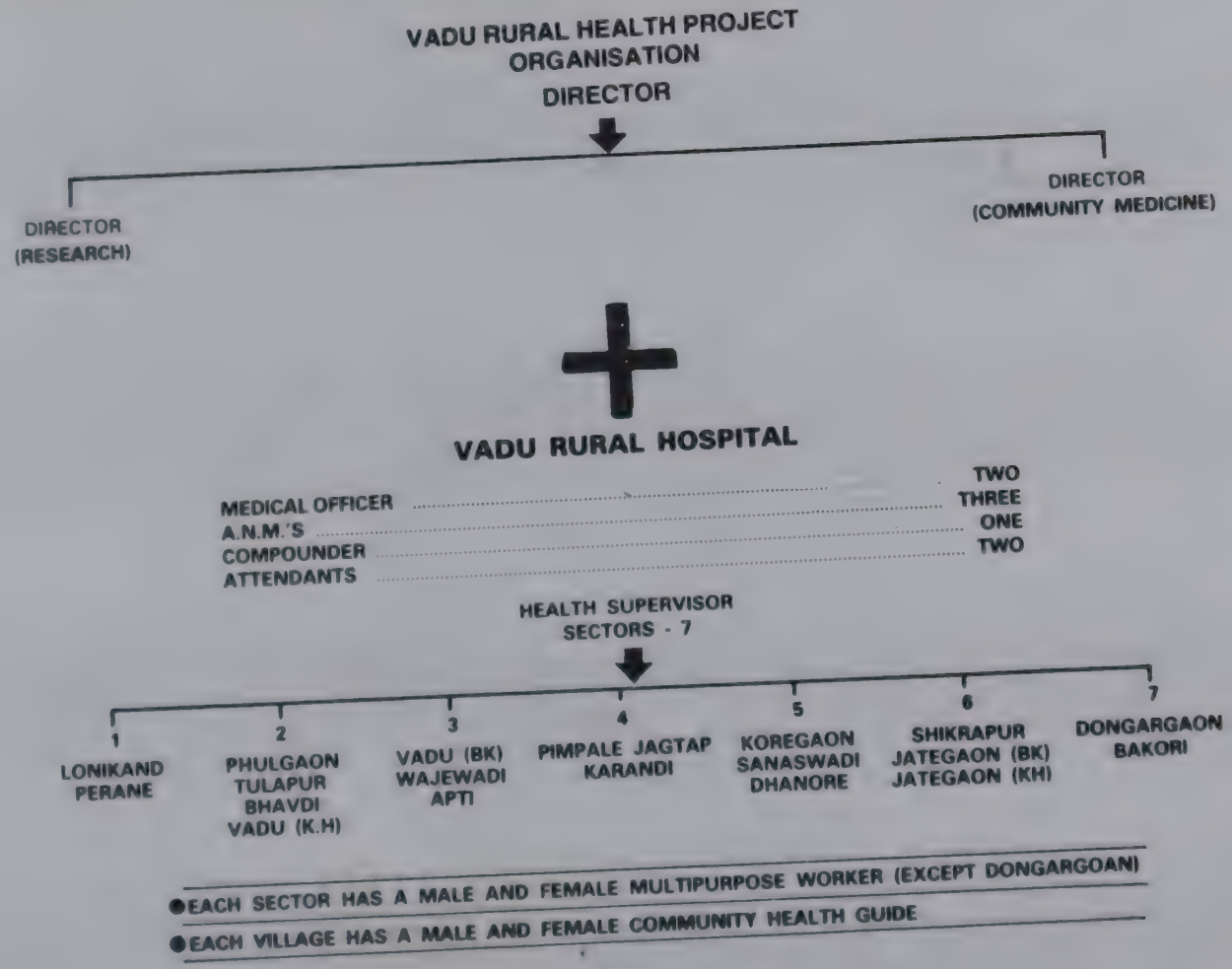
Director (Research) Director (Community Medicine)

VADU RURAL HOSPITAL

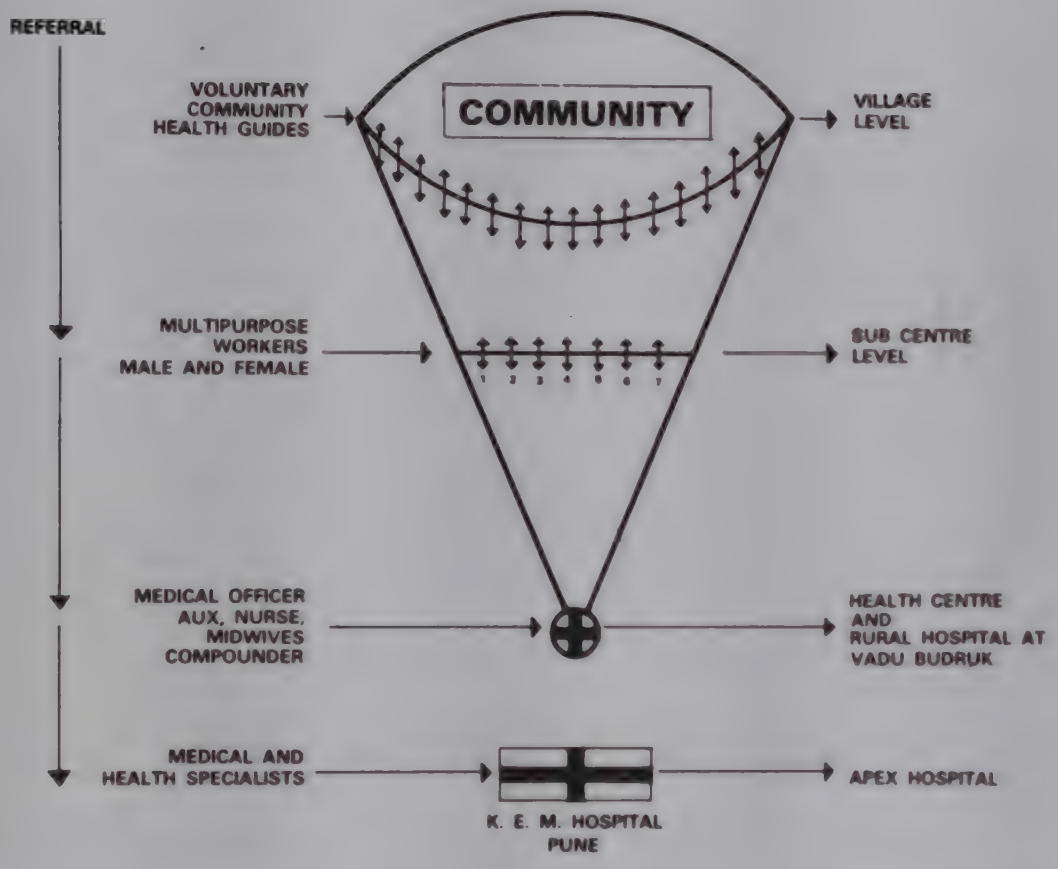
Medical Officer	-	two	Recruited and maintained by
ANMs	-	three	State Government of
Compounder	-	one	Maharashtra and under
Attendants	-	two	administrative control of
Health Supervisor	-	one	the Project
7 Subcentres	-	1 Male MPW	
	-	1 Female MPW	

One male and one female Community Health Guide in each village

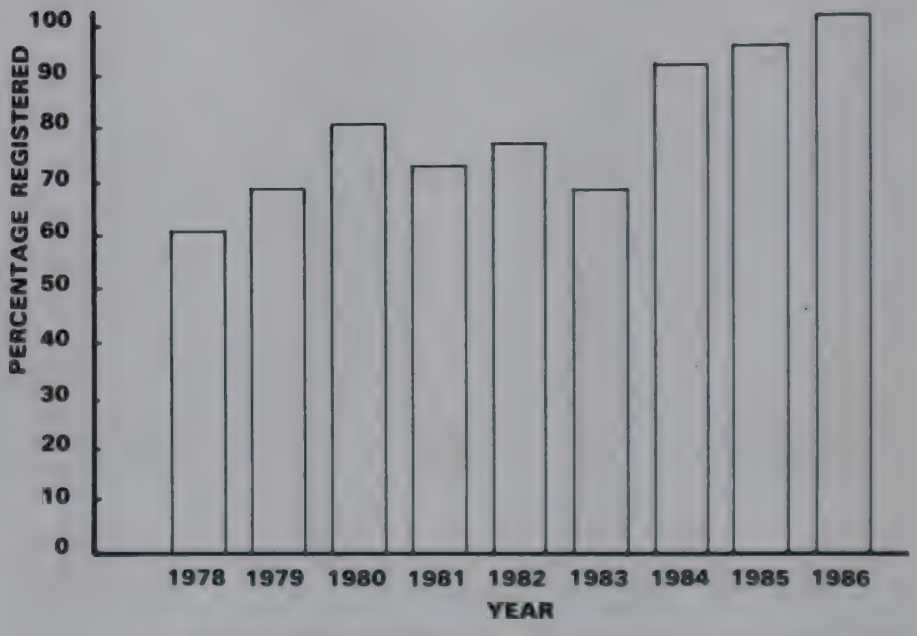
VADU RURAL HEALTH PROJECT


VADU RURAL HEALTH PROJECT
ORGANISATION
DIRECTOR
DIRECTOR (RESEARCH)
DIRECTOR (COMMUNITY MEDICINE)
VADU RURAL HOSPITAL
MEDICAL OFFICER ..... TWO
A.N.M.'S ..... THREE
COMPOUNDER ..... ONE
ATTENDANTS ..... TWO
HEALTH SUPERVISOR
SECTORS - 7
1 LONIKAND PERANE
2 PHULGAON TULAPUR BHAVDI VADU (K.H)
3 VADU (BK) WAJEWADI APTI
4 PIMPALE JAGTAP KARANDI
5 KOREGAON SANASWADI DHANORE
6 SHIKRAPUR JATEGAON (BK) JATEGAON (KH)
7 DONGARGAON BAKORI
●EACH SECTOR HAS A MALE AND FEMALE MULTIPURPOSE WORKER (EXCEPT DONGARGOAN)
●EACH VILLAGE HAS A MALE AND FEMALE COMMUNITY HEALTH GUIDE

HEALTH PYRAMID
OF
VADU RURAL HEALTH PROJECT

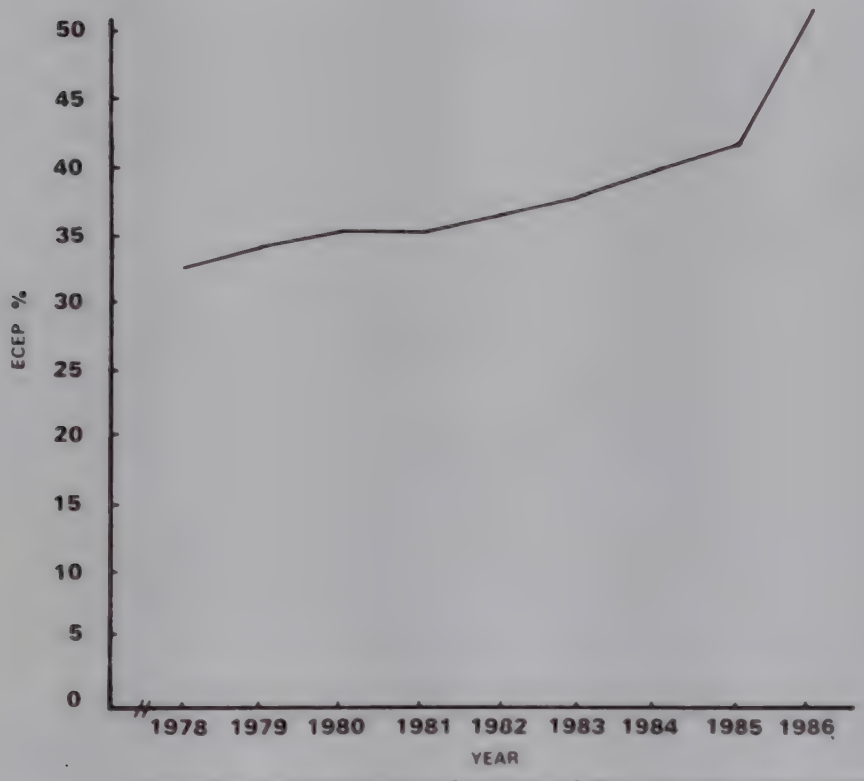


VADU RURAL HEALTH PROJECT
PERCENTAGE OF WOMEN REGISTERED FOR ANTE NATAL CARE
1978-1986



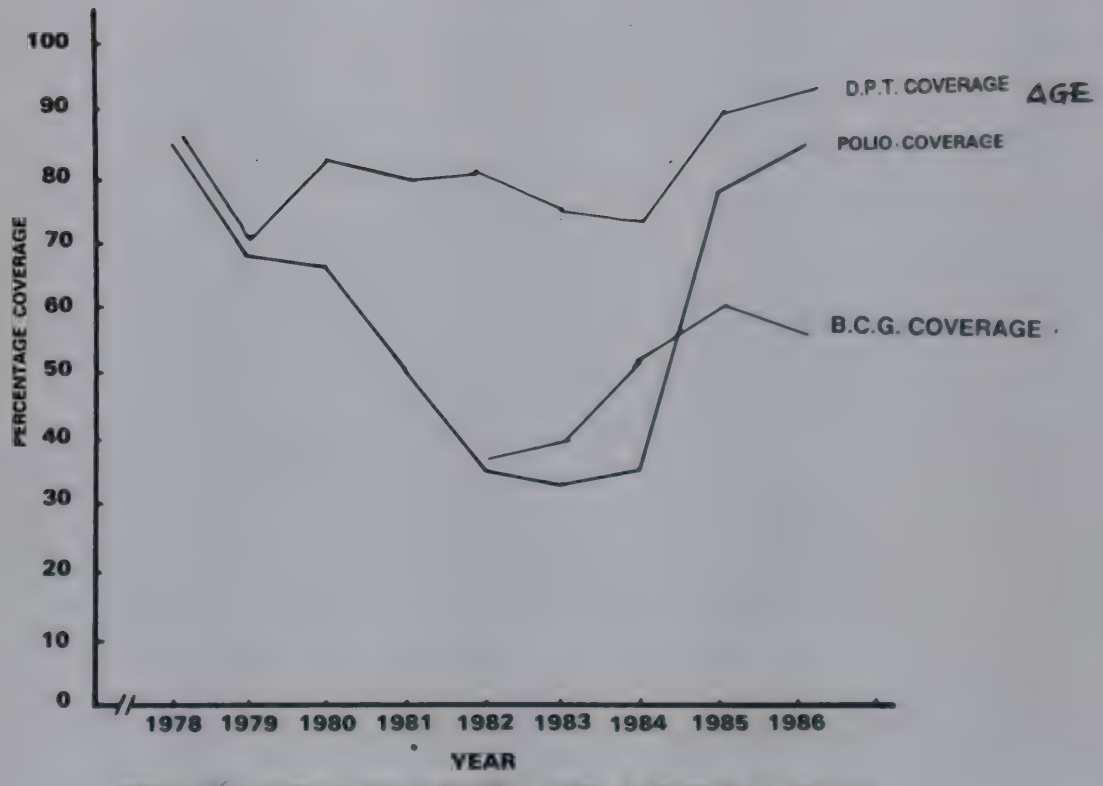
(Based on the assumption that the expected number of pregnant women is 47 per 1000 population as revealed by special enquiry conducted in 1983-84)

VADU RURAL HEALTH PROJECT
PERCENTAGE OF ELIGIBLE COUPLES EFFECTIVELY PROTECTED
(ELCEP %)
1978-1986



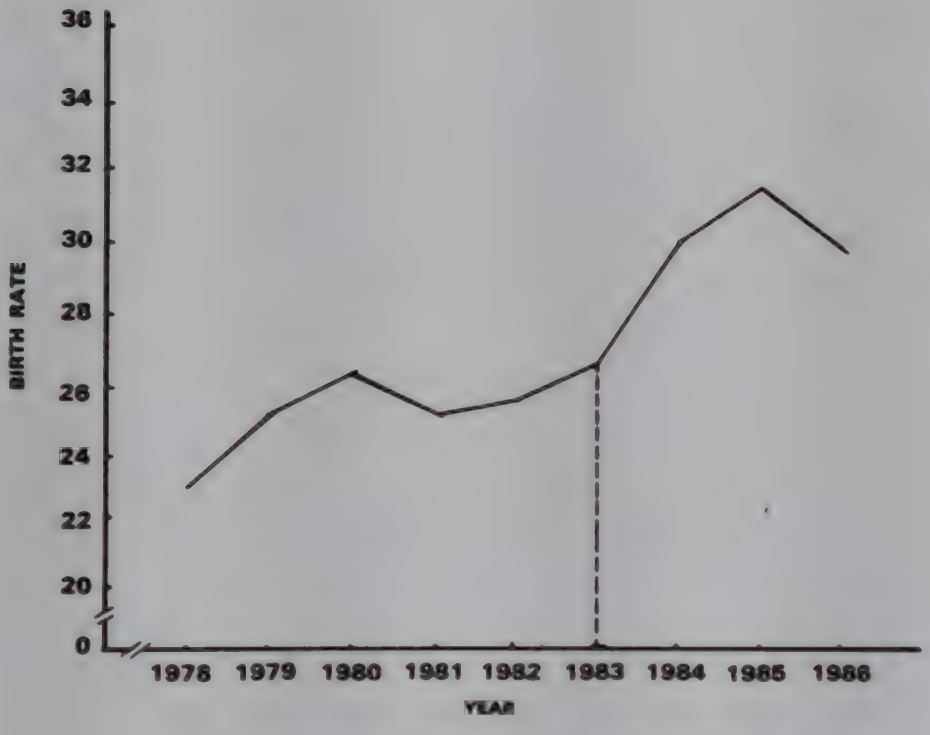
(percentage protection based on Sterilizations & IUD s only after applying attrition rates for 1978–1985. It is based on actual survey for 1986.)

VADU RURAL HEALTH PROJECT
IMMUNIZATION COVERAGE (%)
1978-1986



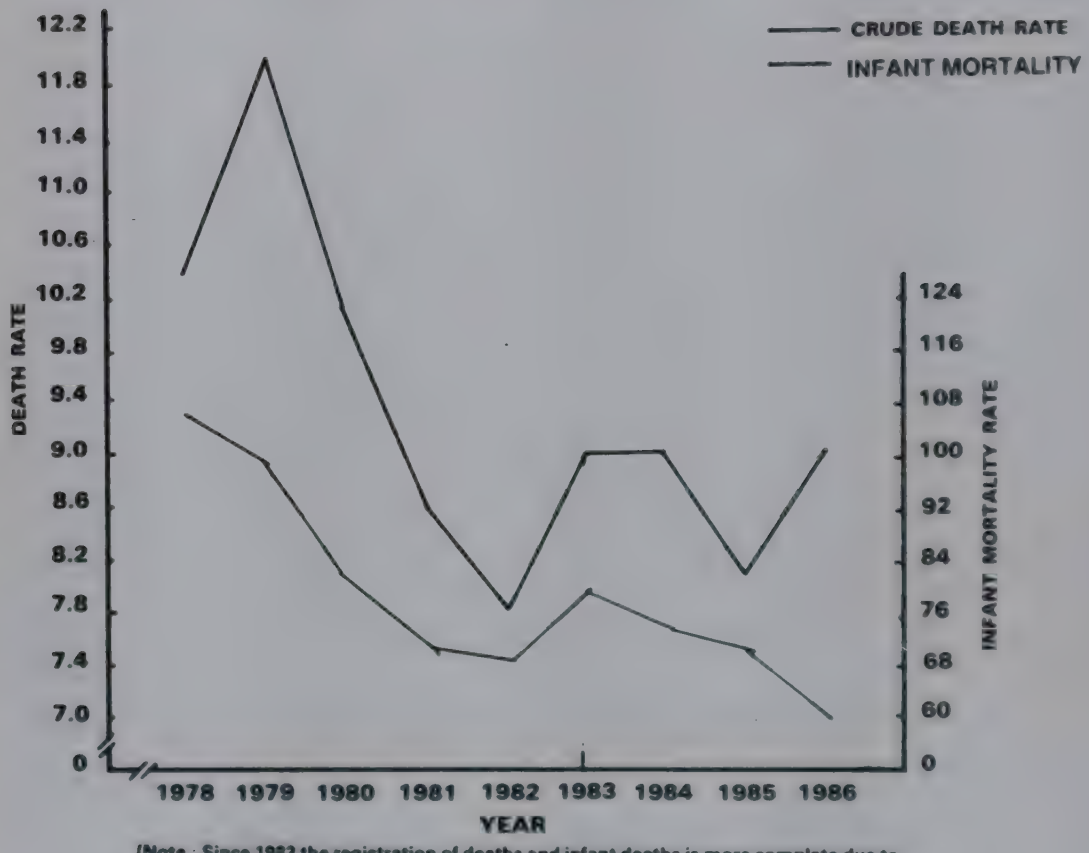
(Note : The percentage coverage for DPT and Polio is calculated on estimated population in 0-4 years agegroup for 1978 and 1979 and on dejure livebirths from 1980 onwards. The BCG percentage coverage is calculated on estimated population in 0-2 years agegroup for all the years.)

VADU RURAL HEALTH PROJECT
CRUDE BIRTH RATE
1978-1986



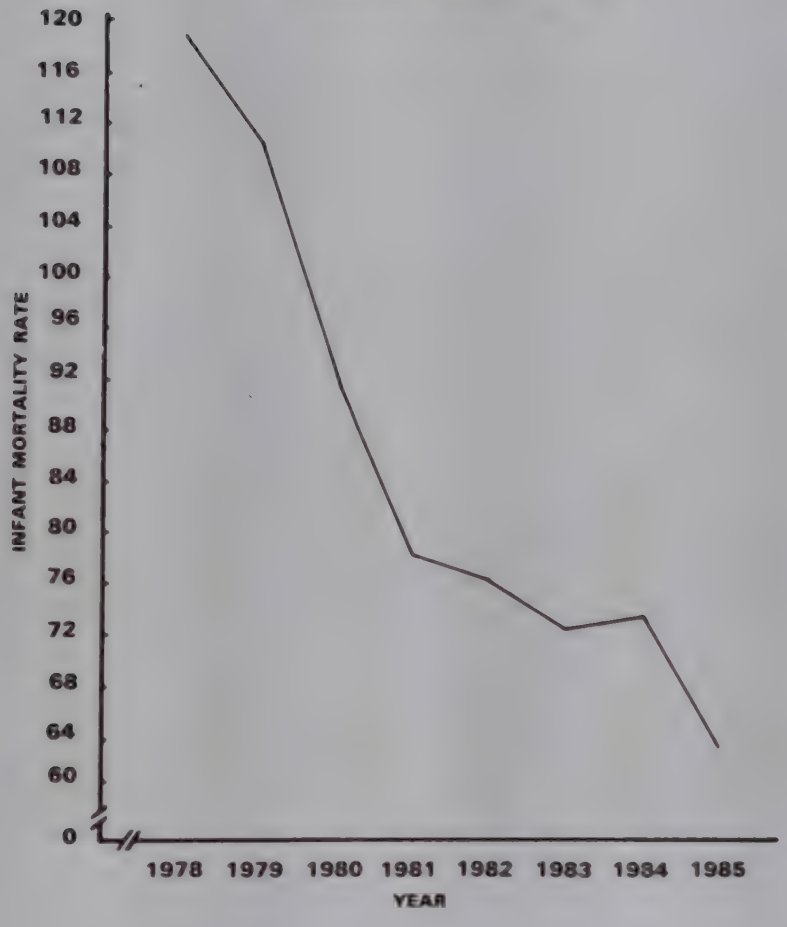
(Note : Since 1983 the registration of births is more complete due to close monitoring)

VADU RURAL HEALTH PROJECT
CRUDE DEATH RATE & INFANT MORTALITY RATE
1978-1986

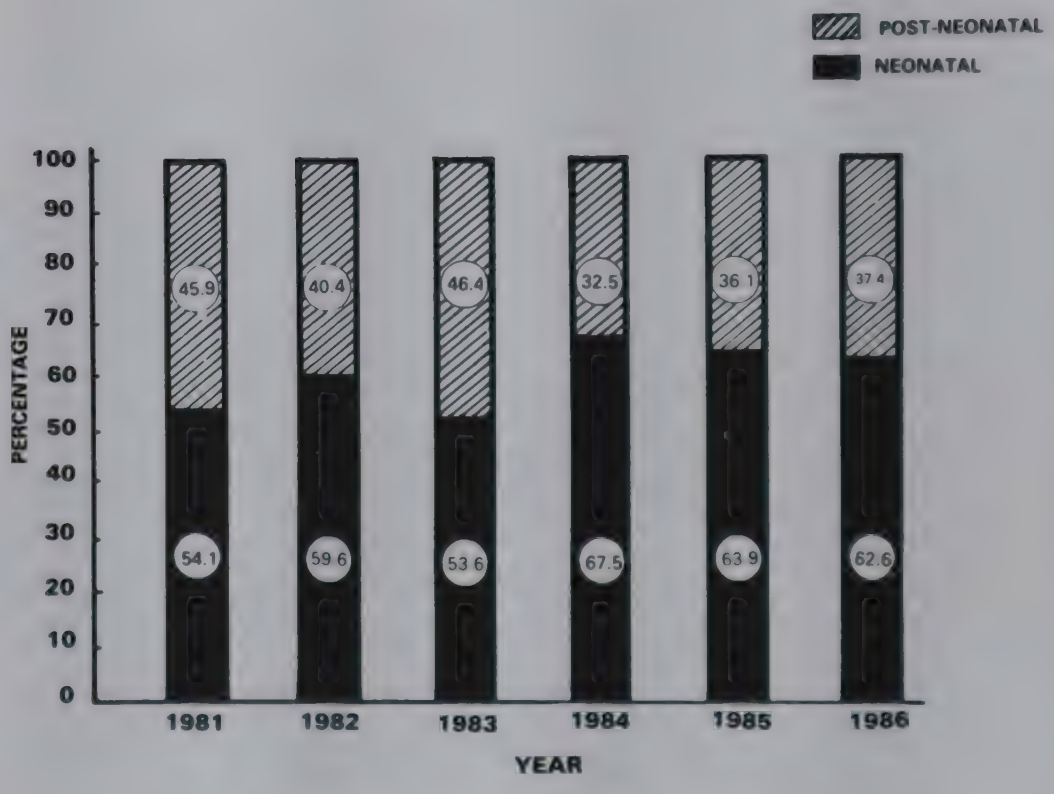


(Note : Since 1983 the registration of deaths and infant deaths is more complete due to close monitoring.)

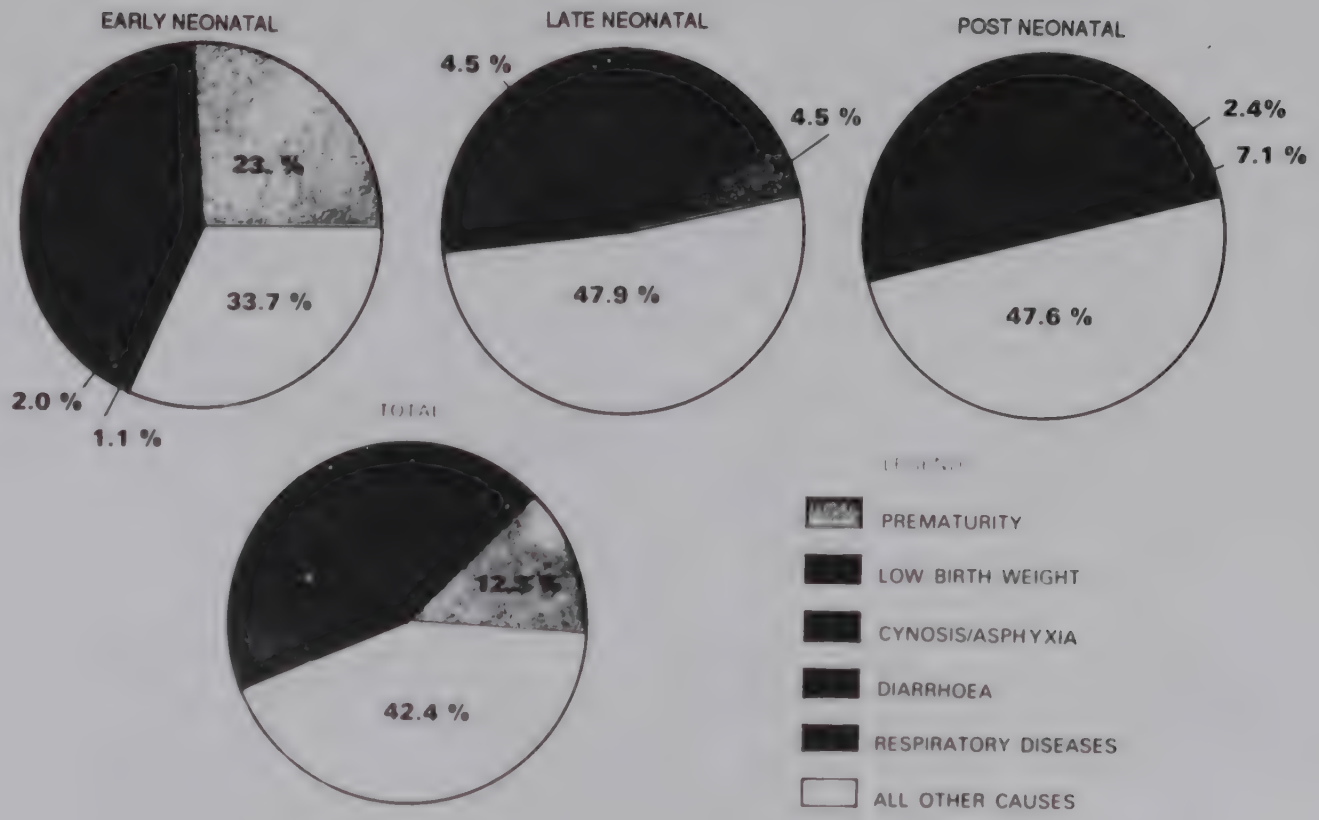
VADU RURAL HEALTH PROJECT
INFANT MORTALITY RATES COMPUTED
THROUGH SPECIAL ENQUIRY



VADU RURAL HEALTH PROJECT
PERCENTAGE OF NEONATAL AND POST-NEONATAL DEATHS
AMONGST INFANT DEATHS
1981-1986



VADU RURAL HEALTH PROJECT
CAUSES OF INFANT MORTALITY BY AGE
* YEAR - 1984 *



Case Study: XIII

THE BANDRA HOLY FAMILY HOSPITAL SOCIETY - COMMUNITY HEALTH PROGRAMME

This is an account of outreach services being provided to slums in the nieghbourhood of a large mission hospital, with a community participation approach, instead of the conventional approach of charity doling of services .Slum population in a metropolitan city are difficult to reach out to and organize, on several counts. For quality of life overcrowding, alcoholism,hetrogenity of the population and high turnover of population are the rule, as compared with the relatively more cohesive and stable rural populations. In this situation, the experience and learnings of the Bandra Hony Family Hospital Society with the slum population of Bombay is relevant and timely. With the urban population in India poised to cross 450 million (or 40% of the Indian Population) by 2000, and almost 20-35% of them expected to be slum dwellers,we have a tremendous task ahead, to organize preventive and promotive services side by side with sophisticated curative services being developed in urban India. There is a great need for hospitals in the cities to reach out to the poorer slum neighbours for whom much can be done at little cost and with little resources, provided, the will can be mustered to offer the relevant services to the community to utilize and also throw in their might towards creating a partnership for health.

THE COMMUNITY SERVED

The project is a comprehensive health care outreach project, aimed to cover the urban slums of Bombay and the population living in the immediate vicinity of the Holy Family Hospital. The Community Health Programme is envisaged to be slowly expanded to cover as many areas as possible, in close collaboration with other voluntary agencies which are already working in slums for social welfare or on other specific issues.

Within the slum population, the priority target population are the mothers and under-five children, around whom most of the preventive and curative services and health work is organized. In addition, other preventive aspects of community health like nutrition, sanitation etc. are also included.

Thus essentially, the community health programme is predominantly MCH -oriented, along with health promotive aspects for the rest of the population. It is attached to the Bandra Holy Family Hospital's Community Health Department.

The project until 1988 covered a population of 15000 slum dwellers in Bandra East, West and Andheri. Since 1988 the project is covering slums only in the vicinity of the hospital in Kantwadim, Jaffarbaba and Mount Mary, a total about 6000 slum dwellers. Annually, there is a turnover of about 10-20% of families. A survey conducted in 1979-80 showed that the monthly income of these families was very low especially in the context of urban living. 27% of families had a monthly income of less than Rs.200/- per month, 57% had an income between Rs 200/- to Rs.500/- and 16% had an income above Rs.500/-. 39% of mothers were employed as domestic servants or other petty occupations. Being situated in Bombay, literacy was as high as 70% in the total population with 58% of women being literate. Yet health indicators showed high morbidity, poor health status

and mortality. Family planning practice prevailed among 37% of the families. Death rate was 9.3/1000 population, with deaths among underfives accounting for 60% of total deaths. Infant mortality was 130/1000 live births.

Among the overall deaths, diarrhoeal deaths (among infants) were the major cause of death which accounted for 16%;jaundice, tuberculosis and accidents accounted for majority of adult deaths. 68% of underfives were undernourished and 31% were severely malnourished.

This was the health situation inspite of a doctor; population ratio of 1 to 700 in Bombay, comparable to Western countries . A number of government and private sector doctors were available in the areas, but owing to several factors, namely apathy of staff, prolonged waiting periods, shortage of drugs and lack of knowledge, the services were underutilized.

Medical treatment during sickness was availed mostly from private doctors. This was in spite of the fact that the bulk of State Government's health expenditure was being consumed by Bombay city alone.

THE PROJECT: BEGINNING AND OBJECTIVES

The Community Health Programme outreach services to the slums was started in 1979 by the Holy Family Society in response to the felt need of various voluntary agencies working in the slums on social and economic issues. The agencies as well as the communities served, felt the need to do something about sickness in the community. In the context of limited resources, the need arose for a community health programme focussed on preventive measures utilizing the services of the local community and the local resources. The results of a community health-cum- socioeconomic survey showed maximum morbidity among underfives, and mothers, most of it being preventable morbidity. Based on these, findings a pilot project was begun in 1979 in the same slums where the other voluntary agencies, particularly the Slum Rehabilitation Society (S R S) Bandra East, Community Centre and Holy Spirit Hospital, Andheri, were already working. The specific objectives were as follows:

i. Completion of immunization for triple antigen and polio in 80% of children.

ii. Improvement of nutritional status in 50% of severely malnourished children.

iii. Change in health attitudes regarding infant feeding, maternal and child care, environment and social welfare

iv. Reduction in infant, underfive and overall mortality and preventable causes of illness

v. Training of Community Health Workers for grass root level of care

vi. Organizing people for self care in health and development.

In 1988 the objectives of the Project were reviewed and stated as:

1. To improve the health status of the community in the Project area, with more emphasis on mother and child care and preventable problems.

2. To organize health education so that the community is made aware of the root causes of diseases and poverty.

3. To train a core team of workers from the community in working together for their health and development.

4. To work through entry points and programmes besides health such as local issues, children's development, youth activities improving economic status and education.

5. To work towards taking up issues specially related to health on a wider basis of people's organization in the urban context.

PROCESS OF PROJECT IMPLEMENTATION AND ACTIVITIES

Towards these objectives a three-tier health system was devised. At the community level, middle-aged, motivated women, well accepted by the community were selected and trained at the Holy Family Hospital as community health workers (CHWs) both through theory and practical classes. The emphasis was on maternal and child health, importance of recording vital events, preventive health practices of clean drinking water, good sanitation, oral rehydration, nutrition, immunization and family planning. The CHW makes regular home visits and also assists in community organization. The community health worker is paid a stipend depending on the number of families she takes care of and her hours of work. She gives simple treatment and advice in her area.

Since 1988, two community health assistants are working part time. They are from the community and have completed one year training at the hospital. They are presently carrying out the work at grass root level and administrative work.

At maternal and child care Centres which are held at the Community Centre, both curative and preventive measures like immunization, and growth monitoring are done. Any sick person of the community needing hospitalization or specialised care is referred to the Holy Family Hospital.

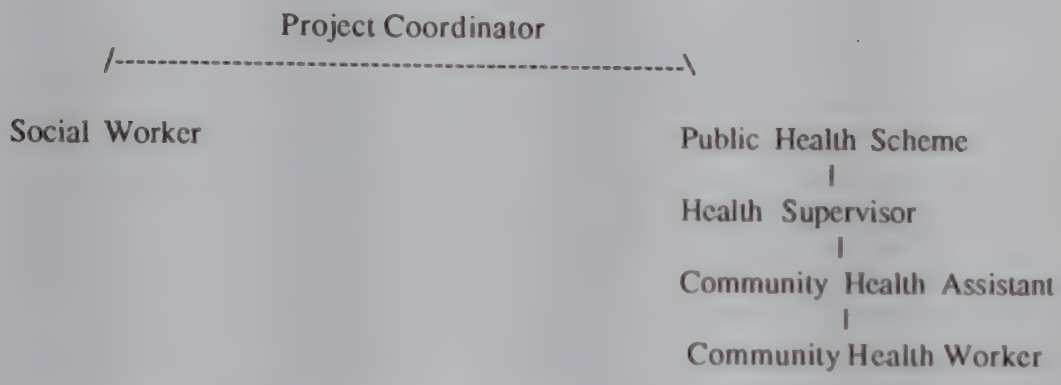
Since 1988, patients are referred by the community health workers and health assistants to the OP clinic of the Community Health Department of the Hospital or to the general out-patient department of the Hospital. Curative services at the community level is through the community health assistants. Antenatal and postnatal care is provided at the hospital only. Concessions, are offered to referred patients for hospital care, I P Case and deliveries. Mostly essential drugs are used, and medicines of good quality are ordered in bulk. Before 1988 maternal and child clinics were held in the community with a doctor in attendance. Now , since slums are in the vicinity of the hospital, referral care is given at the hospital.

In addition, underfives and pregnant mothers are given nutrition supplementation under the Government nutrition scheme of the Social Welfare Department. Two such nutrition centres are in operation. The two workers supervising this programme were also trained by the hospital team to do community health work.

School health is also a part of the activities. Regular check-up and health education are carried out. About 300 school children are included in the programme. They are given health education and opportunities for physical, cultural, creative and recreational activities, together with their regular school tuition programme.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The project functions under the overall leadership and guidance of the Project Coordinator - Dr Ancilla Tragler who is the pediatrician and Head of Department of Community Health, of the Holy Family Hospital. The organizational structure is as follows.



PROCESS OF COMMUNITY PARTICIPATION

Community participation in this project should be viewed within the context of an urban population with relatively high population turnover (compared to the fairly stable rural population). This results in a relatively fluid community with lesser opportunity for any agency to make a lasting impact in terms of organizing and educating the community. Within this context the participation of the community is as follows:

i) The community has availed and accepted the preventive services much more than could be expected, given their socioeconomic conditions.

ii) The community has donated the space for the Community Room for health and developmental activity.

iii) In the area of some Community Clinics, each family in the community pays a monthly fee which goes towards maintaining the staff and towards drug costs. Nominal contributions are made by the community for curative care.

iv) The Community Health Worker is a person from the community and she has succeeded in carrying the health messages to the people, a fact which is reflected in marked improvement in health indicators, since the start of the project.

v) Community participation and organization is mainly through Mahila Mandals and people's groups. Awareness building, and then planning and action are steps taken for people's organization. Women have collectively been involved

in solving social and environmental problems of health, like cleanliness, sanitation , water, exploitation by power groups, etc. Parents have become involved in the promotive aspects of health and have changed their attitudes towards better health practices. Nonformal education, literacy classes, job training programmes, legal rights for women and households have become the means by which people are fighting the root causes of illness and poverty.

RESULTS

The change in health status has been steered through the strategic role of the community health workers who were appropriately selected, trained and given continuous support for effective performance of simple but meticulously carried out duties. This was backed up further by regular second level care at the community clinic conducted by a team headed by a doctor, and the referral hospital services by the Holy Family Hospital.

The results in terms of health status have been quick, given the relatively static socioeconomic conditions. Infant mortality has come down from 132/1000 live births to 31/1000 live births. OVerall mortality in the population increased from 9.3/1000 to 7.6/1000. Very few diarrhoeal deaths occurred after the project was implemented in these areas. Malnutrition incidence in underfives dropped steeply. A health survey conducted three years after the start of the project showed remarkable health awareness, awareness of infant feeding practices, child care, and environmental sanitation. Immunization coverage for children went upto 80%.

Even in the new slums that were taken up since 1988 immunization coverage of 99% for Triple antigen and Polio was achieved, from a baseline coverage of 60%. Death rate has decreased from 9 to 6 per thousand population. Prevention of underfive deaths has reduced from 46% of all deaths to 35%. Majority of the population are still in the low socioeconomic group.

Eightyfive health workers have been trained so far through the programme. An evaluation study done in 1987 showed that the community appreciated both the promotive and curative role of the health worker.

Health education is very effective and responsible for the positive impact of health care in the programme. Assessment of health knowledge of both mother and school children reveal good knowledge and change of health attitudes. People have also organized themselves for their health needs.

People are thus made responsible for health care at the grass root level with the hospital being available for referral specialised care. The Project has shown that health promotion and simple treatment with peoples involvement can make an impact on the health of slum population.

COLLABORATION AND CONFLICTS

The project leadership has sought to collaborate with the government as far as possible. Vaccines are procured from the governmental agencies. The nutrition supplementation to underfives and pregnant mothers is provided under

the government's nutrition programme. Otherwise, generally, the project functions as a parallel health service in the area.

Collaboration with other voluntary agencies has been marked from the beginning of the project. In fact, it was partly in response to the felt need of voluntary agencies already working in these slums, that the community health programme was started. In most of the project areas, the entry of the Holy Family Hospital society has been facilitated by previous work on social issues, by these agencies. Health workers of other voluntary agencies have been trained in the Hospital.

After successfully implementing the community health programme for a few years they have been handed over to the voluntary agency concerned with the project. The Holy Spirit Hospital has its own community health project. The B E C C and S R S have their own programme and request assistance when required. Concessions are offered at the Holy Family Hospital to patients referred by other voluntary agencies. The programme has coordinated with other academic and teaching institutions for joint projects, workshops, training programmes, producing health education material and publishing various studies.

Conflicts have arisen mainly with exploitative powers in the community. Health workers have to found it difficult to establish their role in a community oriented to doctors and medicines .

FINANCIALRESOURCES

The programme was first sponsored by CEBMO and now by Terre des Homes both of Netherlands. People's contribution is mainly for curative care, fees which are nominal charges only. Government resources are used for obtaining vaccines and for the nutrition programmes. Concessions are given by the hospital for specialised care, investigation and admissions. By and large the major source of funds for the project continues to be the overseas donor.

LEARNINGS FROM THE PROJECT

The Project demonstrates the potential role that urban hospitals can assure in providing outreach health care for the slum dwellers. In spite of a relatively fluid community situation due to inmigration and out-migration, and appalling health and socioeconomic conditions in these slums, a strategy of training community health workers, from the community itself, combined with a leadership committed to primary health care for the slums, was able to achieve the health for all goals in the slum community, well in advance of the targeted year of 2000 AD.

Case Study:XIV

NUTRITION REHABILITATION CENTRE - MADURAI

The Nutrition Rehabilitation Centre at Madurai in Tamil Nadu, is aimed at nutritional rehabilitation of under-five children who are at risk of developing blindness due to malnutrition, specifically, deficiency of Vitamin A. The centre was sponsored in 1971 by the Royal Commonwealth Society for the Blind, with the understanding that Prof. G Venkataswamy, Head of the Dept of Ophthalmology of the Government Rajaji Hospital and Prof. K A Krishnamurty Professor of Pediatrics would take charge of the Centre. Subsequently, village outreach services were also started for family-based prevention of child malnutrition. This project has been essentially an institution - centered project with the NRC and its objectives as the nucleus around which it has been built. Essentially, the objective of the Project is to provide specific type of outreach services with the co-operation and involvement of the community, and as such, the extent of community participation and self-reliance has been limited to activities related to prevention and rehabilitation of childhood malnutrition.

The following is an account of the efforts of the agency in prevention and control of nutritional blindness in the area.

THE COMMUNITY SERVED

The Nutritional Rehabilitation Centre (NRC) near the Government Rajaji Hospital at Madurai takes in malnourished children below the age of five years, who show signs of imminent or existing blinding malnutrition. Most of the cases are referred from the Government Rajaji Hospital, other physicians and practitioners of Madurai city and neighbouring villages. Thus, there is no clearly defined community or area served by the centre.

The Village Child Care Centre Project, a wing of the NRC serves a community consisting of a population of about 30,000 living in 46 villages, near Madurai. Within this population, the target group of the NRC constitutes children under the age of five years, who are enumerated and kept under nutritional surveillance.

THE PROJECT - BEGINNING AND OBJECTIVES

The Nutrition Rehabilitation Centre was set up in 1971, following increasing awareness at the global level, of the prevalence of blinding malnutrition in Africa and Asia. Specifically, in the context of India, the need to do something about it was urged by Professor G Venkataswamy at the General Assembly of the World Council For the Welfare of the Blind held in 1969. As a follow-up, a specific proposal was made by Dr Bengoa of the World Health Organization Nutrition Unit, to set up Nutrition Rehabilitation Centres for malnourished children which would be residential rehabilitation centres. The Centres should aim for complete nutritional rehabilitation including training of the mothers in child nutrition rather than function merely as a supplementary feeding unit.

On this pattern the NRC, Madurai was started by the Royal Commonwealth Society for the Blind, near the Government Rajaji Hospital. Subsequently, in 1973, with the sponsorship of the Government of Tamil Nadu and a foreign funding agency, the Associated Country Women of the World (ACWW), a rural programme was started to reach out nutrition rehabilitation services to 46 villages located within 40 Kms from Madurai.

The objectives of the Nutrition Rehabilitation Centre are:

i) To treat malnourished children

ii) To educate mothers on how to feed their young children adequately with low-cost, nutritious, locally available food at home.

iii) To develop the NRC into a teaching and training centre for those involved in nutrition programmes.

The objectives of the Village Child Care Scheme are as follows:

1. To be community-based so as to give maximum participation and satisfaction to the village population.

2. To control and prevent malnutrition with special emphasis on prevention of blinding malnutrition.

3. To educate the mothers through demonstrations and health talks, as to how they could prevent malnutrition occurring in their children, by the use of locally available low cost foods.

4. To reduce morbidity by providing medical assistance under a doctor's supervision.

5. To bring down Grade III malnutrition by 60% within a specified time and so limit the incidence of eye lesions due to Vitamin A deficiency.

6. To educate, using audiovisual aids, the village people in general and the school children in particular on causes and prevention of malnutrition.

7. To develop village as field practice areas.

8. To provide immunization coverage for all children and tetanus toxoid for expectant mothers.

9. To collaborate with the Government Departments of Education, Health, and RuralDevelopment.

ACTIVITIES

The Nutrition Rehabilitation Centre along with the Village Child Care Centre Project, restricts its activities to nutritional rehabilitation of children, particularly the underfives. Activities include initial supplementary feeding followed by training of mothers to maintain nutrition of the children subsequently.

The activities of NRC are carried out at two levels. At the Centre in Madurai City, mothers and children are admitted for rehabilitation of malnourished children. Here the work is restricted to patients referred from the Government

Hospital and by other practitioners. In the Village Project the same nutritional rehabilitation services are reached out to the population of 46 villages through the Village Child Care workers and the Bala Sevikas trained by NRC for the purpose.

A. Activities at the Centre

1. Children are referred to NRC from the Government Rajaji Hospital (Departments of Paediatrics and Opthalmology) if they show signs of malnutrition or risk of developing eye complications of malnutrition. On admission (along with the mothers), they are subjected to medical examination to determine the grade of malnutrition, concomitant diseases, etc. by the pediatrician and ophthalmologist of the Government Rajaji Hospital who also attend the NRC. The dietary regimen and other supplementary treatment such as deworming, treatment for diarrhoea, etc., are decided upon, and the child is to put on the nutritious feeds along with treatment. Until the child progresses satisfactorily, he and his mother are not discharged.

2. Mothers of admitted children are divided into three groups for training during their stay at NRC. The first group is involved actively in helping the staff slowly feed the children, personal hygiene, hygienic care of infants and children, recognition of signs of under-nutrition, health education for determining nutritional needs of children,etc. The second group is posted to the kitchen to help the cooks to plan and prepare the daily nutritious meals from low cost locally available seasonal foods (the vegetables and fruit is mostly collected from the kitchen gardens of the NRC), hygienic preparation of foods,etc. The third group of mothers is posted to the kitchen garden to help maintain the garden, where the vegetables to feed all inmates of the Centre, Papaya trees, drumstick trees and seasonal fruit trees are grown. The mothers are posted thus, to demonstrate how, low cost nutritious food such as green leaves, vegetables, papaya, etc., is within the reach of almost every mother to provide for her child.

In addition, wherever the mothers are posted they are taught about birth spacing, hygiene and household budgeting all of which are useful to have healthy children. The importance of maintaining the growth card of the child, home treatment of diarrhoea, etc. are taught to the mothers. The duration of stay of mother and child depends upon two things - one is the progress of the child, and the other is, confidence of the Centre that the mother has become sufficiently educated and motivated to practice what she has learnt at NRC.

3. A large kitchen garden to grow nutritious vegetables rich in Vitamin A, papaya and other fruit trees, is maintained not only to supplement the food supply for the NRC, but also to demonstrate to the mothers the methods of kitchen gardening at their own homes.

4. Training

a. Training programmes are conducted for child care workers (Balasevikas) working in 46 villages of the Village Child Care Project attached to the NRC.

b. School teachers and staff engaged at all levels in the Governments Applied Nutrition Programme are trained at NRC. NRC has been recognized as a training centre for all categories of personnel involved in this Programme, from Deputy Director to Balasevikas.

c. Many voluntary organizations have sent their health workers to gain valuable experience which can be incorporated into their activities.

d. A number of trainees who are field workers and supervisors involved in the World Bank's aided nutrition programmes, trainees from East Asian Countries deputed by WHO and UNICEF, have been trained at NRC for a period ranging from ten days to four week.

5. Production of Health Education Materials

Colour posters and pamphlets have been prepared in collaboration with UNICEF for the Government of Tamil Nadu to spread the message of healthy nutrition in schools and the general public.. Many are printed in the local language, visual aids, such as educational calendars, flip charts, and film strips have been prepared for use of health workers (including Balasevikas), school teachers, etc. Educational films and cinema slides for health education through mass media have also been produced and are being actively used.

B.Activities Under the Village Child Care Centre Scheme

Under the scheme, the villages selected are covered by the NRC for prevention and rehabilitation of blinding malnutrition.

1. After initial survey and establishing the need for nutritional rehabilitation programme for underfives, suitable girls from the villages whose education has continued upto eighth or tenth grade are selected and given three months training in nutrition - understanding nutritive values of locally available low-cost foods and other relevant knowledge, common diseases of childhood, especially those related to malnutrition, normal milestones of growth, personal hygiene, environmental sanitation, growth monitoring, first aid and emergency treatment. In addition they are practically trained to teach mothers and demonstrate different aspects of child care including nutrition at the NRC. During their training period, the trainees are also posted to the Government Rajaji Hospital in order to study case demonstrations of malnutrition and childhood diseases in the Departments of Pediatrics, medicine, ophthalmology and dermatology. In the NRC kitchen, optimum cooking methods to retain the nutritive value of foods is demonstrated .

2. After training, the Balasevikas attend at the Child Care Centre in the Village where cook is also posted. Children with malnutrition from the village attend the Centre, where their medical records for health monitoring is maintained. Surveillance of children who have completed their period of 100 days of supplementary feeding at the Centre, health education of the mothers in nutrition and child care, planning and supervising the cooking of the supplementary food at the centre, are some of her duties.

3. Children admitted to the feeding programme of 100 days are given cooked supplementary feeds during the daytime consisting of a breakfast, snack and lunch, cooked at the Centre.

4. The doctor, public health nurse, and nutritionist from the NRC visit the Centre and run the weekly clinic (at the rate of two to three neighbouring Village Centres per day), to identify the children to be admitted to the feeding programme, examine the sick and manlnourished children who may be treated locally or

admitted to the NRC headquarters; the public health nurse educates the mothers on nutrition, oral rehydration therapy, child care, etc.

The balasevika is overall incharge of the Centre, maintains the records, and identifies the village children who have to been seen by the doctor, and takes charge of all other maintenance activities in connection with underfive's health.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The Nutritional Rehabilitation Centre functions under the overall guidance and inspiration of Dr G Venkataswamy who is also in charge of the Aravind Voluntary Eye Hospital at Madurai.

The staff of the NRC includes doctors, public health nurses, nutritionists, cooks, gardeners to run the kitchen garden, and other supportive staff. At the Village Child Care Centre level, in each of the 46 villages, one Balasevika, and one cook run the activities. Balasevikas are resident in the quarters provided, and are usually from another village to avoid bias in selection of children. The cook is a local person paid a monthly wage of Rs.30/-.

In addition, a vehicle is provided to transport the team for their weekly visits to the Child Care Centres.

PROCESS OF COMMUNITY PARTICIPATION

1. The bulk of services of the NRC at Madurai consists of nutritional rehabilitation of referred cases. Community participation in this activity is chiefly in the form of availing the services, and to some extent, participation by the mothers in the form of learning and implementing health and child care prac tices.

2. Mothers of children admitted to the Centre undertake major portion of the work of cooking, maintaining the kitchen garden and cleanliness of the NRC, which spares substantial staff and budget which would otherwise be required.

3. In the Village Child Care Centre Project, the NRC team of doctors and public health nurse had first contacted the community leaders, Mahila sanghams, etc., to explain the objectives of the project, and then only the NRC initiated the project in the village. A a result of the enthusiasm of the villagers,the community in most of the villages, has donated accommodation for the centre and for the residence of the Balasevikas, free of cost. In addition, some land has been donated for the kitchen gardens in certain villages.

4. Local women work as cooks at the Child Care Centre on a small monthly salary of Rs.30/-. The cook in addition to cooking food for the beneficiary children under the supervision of the Balasevika, also escorts some children who have nobody to escort them to the Centre.

5 Mothers of children admitted to the feeding programme attend the Village Centre atleast once a week on the weekly clinic day to watch the treatment, have nutrition and health education and learn to spread the message in their neighbourhood

RESULTS

Since the NRC Madurai does not have a specific demarcated community , and, the Village Project evaluation is not undertaken as a rule, the impact of the nutrition programme on the community is difficult to assess. However, the NRC through its activities has been able to treat annually, an average of about 300 cases of protein-energy-malnutrition and eye complications due to malnutrition every year, thus preventing substantial incidence of childhood blindness in the community.

COLLABORATION AND CONFLICTS

1. From the beginning of the Project, the NRC has been obtaining technical support,guidance and facilities for clinical training from the Government Rajaji Hospital. NRC was started by the Royal Commonwealth Society with the understanding that Prof Venkataswamy and Dr Krishnamurthy of the Government Hospital would take charge of the Centre. Even now, after their retirement, the specialists (ophthalmologist and paeditrician) of the Rajaji Hospital guide the doctors and staff of NRC in their work.

2. The Village Child Care Centre Scheme which is being carried out by the NRC is jointly sponsored by the Government of Tamil Nadu and an international voluntary funding organization, ACWW.

3. The Government of Tamil Nadu deputes its personnel involved in the Applied Nutrition Programme to the NRC for training in nutrition.

Generally there has been no history of conflict with the Government.

4. Many voluntary agencies depute their health workers to the NRC for training in nutrition.

5. Relationship with the Community

The NRC is basically a service centre offering nutrition rehabilitation and supplementary feeding for sick underfive children who constitute the priority group for the community, especially when they are sick. As such, except in certain isolated villages, where caste prejudices to mass feeding created some conflicts and drop outs, the NRC has been mostly well accepted by the community.

FINANCIALRESOURCES

The funds required for running the NRC at Madurai, are provided by the Royal Commonwealth Society for the Blind, based in London.

The Village Child Care Centre Project has been jointly sponsored by Associated Country Women of the World and the Government of Tamil Nadu. The ACWW funds the training of the Balasevikas, their stipend during training, salaries of the Balasevikas and cooks, purchase of the Standard Van, its maintenance costs and the salary of the driver. The remaining including cost of supplementary

feeding, medical kits containing simple medicine for the use of Balasevikas, and other such items are funded by the Government of Tamil Nadu.

The reccurring expenditure at the NRC, Madurai and the Village Child Care Centres are minimized by reliance on low cost locally available and seasonal foods, growing most of the vegetables and fruits in the kitchen gardens attached to the centres, and utilizing the services of the mothers for bulk of the work of cooking, cleanliness and gardening, as a part of their practical training in nutrition and child care.

Case Study : XV

PADHAR HOSPITAL COMMUNITY HEALTH PROJECT

Padhar Hospital is a 200-bedded hospital of the Evangelical Lutheran Church of Madhya Pradesh with excellent modern facilities in all major specialities and a staff of about 200. It is located just outside the village of Padhar on the Bhopal -Nagpur Road in Betul District, about 20 KM from the district Head Quarter town. The hospital is located in a densely populated area with a predominant tribal population.

In 1976, the Community Health Department was started to provide outreach services for the improvement of health status of the people of 30 tribal villages situated within 10 Km radius of Padhar Hospital. The following account serves as an illustration of the possible role of hospitals in providing outreach primary health care services to neighbouring rural communities.

THE COMMUNITY SERVED

At the start of the Project in 1976, the community served consisted of a predominantly tribal population of thirty villages within a radius of 10 KM from Padhar Hospital. Subsequently, an additional 22 villages within 25 KM radius are being covered since 1986.

GeneralCharacteristics

The tribals are simple people living in isolated groups in small scattered villages in undeveloped forest regions. Majority of the population served are Gonds who have a distinct culture with strong bearings in Hinduism. They have a characteristic dress, and a dialect akin to the Dravidian language more in vogue in South India. The people live off small farms, supporting themselves by farming, gathering minor forest produce, and by casual labour on building sites and roads. The soil is extremely poor with very little irrigation and primitive agricultural practices. Therefore they are very poor and backward; in many villages they continue to use the barter system of trade. Literacy levels are very poor being only about 7% mostly limited to the youngsters. Only 25% of Gond Children are ever enrolled in the schools.

Health Profile of the Community

The population like most other tribal and primitive rural populations was characterized by poor health status with high morbidity and mortality rates; high incidence of malnutrition of almost 40% among underfive children; high infant mortality of about 133 per thousand live births including high proportion of neonatal deaths due to sepsis and tetanus; prevalence of Vitamin A deficiency in the general population with eye signs being found among 3.7%; and a birth rate of 53 per thousand. In addition, high incidence of poliomyelitis, encephalitis and diarrhoeal diseases were found.

The health services available included the District Hospital at Betul at a distance of 20 KM or more and two Primary Health Centres one to the north and

another to the east;three subcentres located in the project area, each staffed by an ANM.

THE PROJECT: BEGINNING AND OBJECTIVES

The Community Health Project was started in 1976, with a view to provide primary health care services to the villagers and tribals, in the villages where they lived. In the long run, the experiences of Padhar Hospital in implementing village outreach project, were planned to be utilized for planning similar programmes by other major hospitals of the Lutheran Church.

The findings of the baseline survey in the led the project leaders to formulate the following objectives:

i) Reduction in infant mortality by 50% within a period of two years, and reduction of morbidity.

ii) Reduction in the incidence of underfive malnutrition

iii) Reduction of incidence of Vitamin A deficiency by 50%

iv) Increased acceptance of immunization among children and pregnant mothers

v) Increased acceptance of family planning

vi) Widespread health education in health and hygiene

vii) Training of dais

viii)Treatment of minor ailments in the community and referral to the hospital whenevernecessary.

The strategy decided upon to achieve the above objectives were, to provide preventive and promotive health services by involving the local community ;to change the attitudes of the people towards their own health by creating awareness of health and socioeconomic needs; and to provide the community with the means of improving its own health through better utilization of its own resources and development of its potentials.

The objectives and strategy were formulated in consultation with the hospital staff, senior officials of the Government Health Department, Director of Health Services of Madhya Pradesh, the local villagers, as well as health consultants and project leaders from outside.

PROCESS OF PROJECT IMPLEMENTATION AND ACTIVITIES

The community Health Project started with a team of two workers who began to make initial contacts with the community. Subsequently the Padhar Hospital staff working on the Project has expanded to 63 workers including a full time agriculturist, horticulturist and live stock extension workers, to facilitate the agro-economic development of the community.

The health care project was to be based on a village oriented voluntary health policy. Towards this the auxiliaries visit one village each day to meet the Sarpanch and Chairman of the Village Council to explain the need for a health programme and particularly, need for the of women to be trained in primary health care. After satisfactory dialogue, the staff assisted by the village leaders assemble the women of the village for a meeting to discuss health problems, and particularly to identify motivated women to be trained as Village Health Guides. These women are then given a training of five days duration, predominantly to enable them to educate the families in their neighbourhood to take actions for prevention water borne diseases, of to solve sanitation problems, malnutrition problems, prevention of communicable diseases and the need for proper antenatal, intranatal and postnatal care. The sixth day (Saturday) is a day of practical demonstration at the hospital and evaluation of their skills, by the public health nursing supervisor. These voluntary health guides may include motivated traditional dais. Their primary functions are, to educate the community, and to change the attitudes of the people for health.

To provide services at the village level, the Padhar Hospital team worked closely with the village elders to recruit one suitable woman from each village to be trained as Village Health Workers (VHWs), who would take responsibility for providing primary health care services to the village community. The VHWs serve as the link between the hospital and the community. The VHWs give treatment for minor ailments, and in addition, they provide and organize preventive and promotive health services as follows: They organize the community for health education talks by the Padhar Hospital team; identify dais practicing in the area and motivate them for training at the hospital; identify, motivate and refer antenatal mothers and underfives for MCH services; impart knowledge on mother and child nutrition,improvement of family nutrition through soyabean supplementation in the food, oral rehydration therapy,personal hygiene, prevention of Vitamin A deficiency, etc. They are aided in this work by the family based informed work of the voluntary health guides of the village. Breaking traditional taboos against infant feeding, diet of the pregnant mother, cord cutting practices at child birth withholding all fluid for an infant with diarrhoea, and other such deep rooted beliefs are hard to crack and the VHW's systematic work is supplemented by the voluntary health guides.

Activities are carried out in the health related sectors of adult literacy and socio-economic development also. Adult literacy centres have been started in each village mostly in houses donated by the community.These serve as the Centre as well as residential quarters for the adult literacy teachers.

A full time agriculturist and horticulturist along with extension workers, work with villagers to help them improve farm productivity, supplementary income generation,live-stock farming, etc., to strengthen their agricultural and economic base which is a prerequisite for health development. Youth are trained in techniques of bee-keeping, artificial insemination, fisheries, and agriculture, to become self employed and earn some income. The youth are also employed on local development projects such as kitchen gardens, nurseries for fruit tree plantations, digging of wells for drinking water and irrigation, maintenance and repair of hand pumps.

Children are the focus of literacy programmes, particularly those who are school dropouts or grown beyond the age of school enrollment. The older

children rendered literate by non-formal education, as they grow into youth, are encouraged to start classes in their own villages for adults and other children.

The Padhar Hospital Project staff provide leadership and guidance to the villagers to move to the path of development in all major areas, at the same time providing the supportive services and educational inputs. A major element of each of the

above developmental programmes is that, the community is organized into relevant associations to eventually take over the of development in each field. The Health Committees have been formed which are gradually taking more and more initiative in health matters; the Mahila Mandals in Maternal and Child Care and issues related to womens' development; the farmers' clubs to take over matters relating to agricultural development'; the tribal fisherman's societies for promotion and support to fishery as an occupation and livelihood.

In fact as a result of multifarious expansion of the Project activities, the Community Health Development was redesignated as the Community Health and Development Department.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The Community Health and Development Department which initially started with two workers, now has a staff of 63 members. The Community Health team includes a Nursing Supervisor, Auxiliary Nurse Midwives and Health Workers. As the activities of the department were extended to the economic, social and educational spheres, an agriculturist, horticulturist, live stock extension worker and non-formal education worker were added to the staff. The leadership to the Project is provided by a team headed Dr V K Solomon, the Medical Superintendent.

PROCESS OF COMMUNITY PARTICIPATION

A.Participation in Health Activities

1. The voluntary health guides and the village health workers selected from the community and trained at the Padhar Hospital, provide the grass root level primary health care services to the people. They have succeeded in substantially changing the attitudes and beliefs of the community as shown by the changes in health status.

2. The traditional dais have come forward to be trained in aseptic delivery practices which has resulted in markedly better maternal and child health in the community.

3 The Health Committees and other village organizations have started taking interest and community based action for health and better nutrition. There has been a change in the community's agricultural practices, health practices and whole way of life towards better nutrition and health.

B. Participation for Socioeconomic Development

As a result of the activities of the Agricultural Committee, Tribal Fishermen's Society, Farmers Clubs, and Mahila Mandals, supported by the training and technical inputs of the Padhar team, the agricultural practices, croping pattern, drinking water sources and income of the farmers, have changed substantially. Soyabean has been successfully introduced, both as a crop and as an important source of protein in their diet. Fruit trees particularly papayas and others, vegetable gardens for prevention of Vitamin A deficiencies have become a part of the activities of many families. The saplings and plants for fruit trees are provided by the youth of the villages who run nurseries vegetable and gardens.

As a result of informal education to older children, some of them have started informal education in their own villages to promote literacy.

RESULTS

1. Infant Mortality:

The Infant Mortality Rate was reduced from 133/1000 to 108 within a span of two years. The achievement was low, inspite of large scale mother and child immunization and also providing protected water supply. An analysis of infant deaths showed that there were greater number of neonatal deaths because of the prevailing practice of cord cutting. This has since been set right by providing training to the local Dais.

2. Birth Rate:

The estimated crude birth rate was 53 before the project began, and the estimated CBR was 25 at the end of two years. More than one-third of the eligible couples were sterilized during this period.

3. Vitamin -A Deficiency:

Prevalence of Vitamin-A deficiency in these villages which was 3.7% prior to the project was reduced to 1.3%.

4. Malnutrition among the Under-fives:

Malnutrition among the pre-school childred which was of a very high magnitude (40%) in these villages has reduced and at the time of evaluation, the incidence of malnutrition was found to be only 10.9%.

5. Village Health Workers

Trained Village Health Workers are carrying out health activities in 52 villages.

6. Deliveries by trained dais

More than 63% of the deliveries in the project area are now conducted by trained dais.

7. Other General Health Indicators:

The nutritional status of mothers and children in the Project area is much better than before. There has been virtually no case of neonatal tetanus, vitamin-A deficiency blindness, poliomyelitis and encephalitis for the past few years. Diarrhoeal disease has come down. Hundreds of mothers who never knew how to recognize dehydration due to diarrhoea, are aware of and use ORT.

COLLABORATION AND CONFLICTS

A. Rapport with the Community:

The major conflict and resistance came from the community. The Gonds looked upon family planning with deep suspicion and distrust. This might have been due to negative impressions created by instances of forcible sterilizations,complications due to lack of follow-up, etc . The Project leaders realized that it was necessary to slowly and patiently gain the confidence of Gonds.

The Gonds on the whole tend to feel that "what was good enough for my father is good enough for me". Therefore, the changes will only come from within the community and individuals, and it will come slowly.

The Gonds are animists, worshiping spirits in trees, rocks, fields, water and so on. Their acceptance of treatment in the health centres depends upon approval of priests and healers. Thus a child with malnutrition, measles and diarrhoea may be forbidden to consume any milk, eggs, or green vegetables for one month - and consequently the child dies of malnutrition and dehydration. In addition, they have traditional beliefs about family planning, superstitious ideas, like, a child with diarrhoea should not be given anything to drink, and they would not feed a child before he has teeth. All these factors took a lot of time to change before the community began to be involved in health activities.

B. Collaboration with the Government:

Presently there is very little government involvement in the target villages. Government development officials and agencies such as the Block Development Officer, the Extension workers, the Tribal Welfare Department and the District Development Departments were encouraged to become involved in these villages as a means of helping to meet the social, cultural, economic and educational needs of the tribals, which could not be totally met by the limited resources of the Hospital. Also, the community Health and Development Department made several special efforts to develop contacts and relations with the government officials and agencies ,and to secure their help and participation in dealing with socioeconomic problems of the rural masses.

However, there is very little formal collaborative relationship with the Government.

FINANCIALRESOURCES

The Christoffel Blinden Mission of Germany provided the basic funds for a three year project. The CBM is particularly concerned with the work of prevent-

ing blindness and with the rehabilitation of those already blind, and are also supporting the Rehabilitation Centre and School for the Blind at Padhar.

Evangelical Lutheran Church is the major supporter. Funds are also received from many other international agencies. The enclosed financial statement shows the total funds received and payments made on various schemes from 1979 to 1986.

FACTORS IN THE SUCCESS OF THE PROJECT

A. Organizational Factors:

The major factor in the success of the Project was the emphasis on involving the suspicious Gond community right from the stage of planning the health project. Subsequently, the strategy of training the local women, as village health workers and health guides to provide primary health care resulted in a responsive community which changed its attitudes and practices.

Some of the organizational constraints experienced in enlisting community participation of primary health care were:

a) None of the leaders in the team are Gonds and most did not speak Gond. Therefore,there are problems for communication and establishment of trust.

b) Lack of qualified and committed health workers. It was difficult to attract competent workers in a remote area of Madhya Pradesh at low salaries, although other benefits such as housing were available.

c) It was and still is difficult to move about in the inclement weather - hot and dusty, wet and muddy.

d) Financial availability - uncertainty of grants and donations. Some grants originally given by the Government, for family planning were discontinued, which temporarily affected the programme.

B. Community Factors

a) Suspicion of the Gonds Regarding Outsiders: This made it difficult to make initial meaningful contacts. The Gonds have been exploited for generations, and hence do not readily trust outsiders.

b) Attitude of Gonds towards Family Planning: Gonds looked upon family planning with deep suspicion and distrust, due to negative impressions created by instances of forcible sterilizations, complications due to lack of follow-up, etc.

c) Resistance of the Gonds to Change: External change was resisted. Changes in Gonds will have to come only from within the individuals and the community. Through series of education, formation of committees and demonstration of positive benefits of the programme, the Gonds gave their support and cooperation. The success has generated a new type of atmosphere in the tribal community. There is a evidence of new hope among the oppressed.

PADHAR HOSPITAL

COMMUNITY HEALTH AND DEVELOPMENT DEPARTMENT

RECEIPTS, GRANTS, HOSPITAL CONTRIBUTION, SALE OF PROCEEDS

Year	Community Health	Integrated Rural Development	Non-formal Education	Communit Health	Integrated Rural Development	Non-formal Education
1986	3,06,648.61	2,88,277.35	75,980.60	2,75,790.68	1,45,262.08	2,53,748.65
1985	2,38,723.11	68,397.39	1,47,562.36	2,48,465.36	2,32,517.62	2,45,218.93
1984	2,32,695.74	2,57,143.47	4,95,519.81	2,32,095.62	1,71,428.80	3,54,614.19
1983	2,30,779.20	1,91,620.10	2,37,470.65	2,29,290.80	1,83,608.30	1,88,509.34
1982	1,74,187.07	3,59,777.22	---	1,96,818.47	2,84,265.62	39,808.31
1981	1,67,413.12	—	—	1,70,405.56	62,300.00	—
1980	2,52,009.47	—	—	2,44,783.69	—	—
1979	1,88,921.88	—	—	2.03.495.58	—	—
Total 1979 to 1986	17,91,378.21	11,65,215.53	9,56,533.85	18,01,145.76	10,79,281.42	9,81,899.42
Excess of payment over the Receipt as on Dec.86	9,767.55	—	25,365.57	—	—	—
Balance	—	—	—	—	85,934.11	—
Total	**18,01,145.76**	**11,65,215.53**	**9,81,899.42**	**18,01,145.76**	**11,65,215.53**	**9,81,899.42**

Case Study No:XVI

THE UNITED PLANTER'S ASSOCIATION OF SOUTHERN INDIA (UPASI) - COMPREHENSIVE LABOUR WELFARE SCHEME

The case study of UPASI illustrates an effort at enlisting community participation in the organized sector. Workers' families of the tea, coffee, rubber, cocoa and other plantations are covered by the Plantation Welfare Act of 1951, which stipulates that certain welfare facilities including health care be provided by the plantation managements. In spite of substantial medical expenditures (which was what the plantation managements understood as health expenditure), the plantation workers had poor health status which in turn affected their productivity.

In the context of the plantations, owned by private individuals and widely dispersed small, workers communities, the UPASI, which was the association for providing technical and services support to the plantation owners, assumed the leadership role to mobilize the planters for the goal of achieving health and population control among the workers. Added to the constraints already described, UPASI had to be the via-media to bridge the conventional labour-management conflict -- the labourers with their conventional concept of management policies as being purely profit-oriented and management-oriented; the management with its predominant orientation to profitability rather than labour welfare.

The leadership of the UPASI Project patiently implemented a well-worked out strategy which brought the managements as well as the workers together, to work for the common goal of health and family planning popularization.

The following is an account of the spectacular results achieved with the introduction of the CLWS in 1971, in the above context. This project has valuable learnings for administrators and Industrial Associations who can potentially achieve similar results in the organized sector including small and large scale industries in rural as well as urban India, employing nearly 2.5 crore workers or, employees, or an accessible population of approximately 12-14 crore (Ref: Planning Commission, Government of India, 1989:India's Population-Policies and Perspectives).

THE COMMUNITY

The community served by the scheme originally consisted of a population of about 5000 in 1971. The scheme was expanded to cover a population of about two and half lakhs in 1984, and has been increasing since then. More than 42% of plantation owners who are members of the United Planters Association of Southern India in the Western Ghat areas of Karnataka, Kerala and Tamil Nadu have implemented the Comprehensive Labour Welfare Scheme (CLWS). to cover plantation workers and their families. The plantation workforce is employed by the planters as "families" rather than as "individuals" since planta-

tion work required great many women workers . Women workers account for 56% of the workforce.

Prior to 1971, the plantation workers were covered by health, welfare and social security benefits under the Plantations Labour Act of 1951, legislated to cater to the specific requirements of the plantation population. Most of these requirements remained on paper with some rudimentary curative services being provided. As with other lower socioeconomic groups, this population was characterized by a high mortality, infant and toddler mortality, high rates of absenteeism from work, etc. Besides since they worked on plantations in heavy rainfall areas, severe anemia was very common due to hookworm infestation and leeches, which was a major drain on the health of the workers. Baseline information gathered in 1971, reveals that the crude birth rate among them was 41.6 per 1000 population, crude death rate was 9.4 per 1000 , contraception prevalence was about 9.5% of eligible couples . High prevalence of low birth weight (average birth weight was 2.2 kgs.), diarrhoea as a cause of death among infants accounted for 50% of deaths. Health awareness and awareness of hygienic practices was almost nil. Since the plantations were predominantly female labour oriented, the member planters of UPASI were concerned with the high rate of absenteeism by women. Large family size and anemia were implicated as major causes of absenteeism of the women workers which hampered the productivity at the plantations.

In this context the Comprehensive Labour Welfare Scheme was launched.

THE PROJECT :BEGINNING AND OBJECTIVES

This Comprehensive Health Project named the Comprehensive Labour Welfare Scheme (CLWS) initially commenced as a USAID funded Project to implement family planning among plantation workers. Plantation workers are fixed population and therefore considered amenable to a planned thrust for family planning. Intially, the scheme was incentive-oriented to implement the small family norm among the plantation families by introduction of No Birth Bonus Scheme. Under this Scheme, women workers who registered themselves were entitled for a fixed deferred contribution by the Management every month, during the period that they did not have a childbirth. The Maternity benefit which she availed in case of childbirth was deducted from the accumulated sum at her credit, which would be awarded to her at the end of her reproductive life. However, it was experienced that the supportive health services network required to service the registered women to effectively contracept did not take off. Thus, the scheme collapsed due to failure of provision of supportive service for contraception. Following this the USAID involvement was withdrawn.

Subsequently in 1972, Government of India came forward with a grant to extend the scheme and strengthen it with supportive health services. To execute the project, Dr(Mrs) V Rahamatullah, a physician with field experience of maternal and child health and family welfare was recruited as the Medical Advisor. She steered the UPASI towards a new course,totally remodelling the incentive-based family planning-oriented CLWS, into a comprehensive health project based on maternal and child health, health education, and better child survival through preventive services. She led UPASI to recognize that the isolated family

planning programme cannot make much impact without a dynamic participation of the management, the medical services and the community.

The philosophy of the UPASI' CLWS has been to convince plantation managements that health is to be viewed as a long term investment rather than a statutory expenditure. UPASI gathered factual evidences to convince the plantation managements - for instance among a group of 240 anemic women workers, the half who were given iron supplements improved their tea plucking performance by 50% as compared with women workers who received no supplementation. Similarly the number of days worked by women taking iron tablets increased by 34%. Supervisory staff found the women taking iron supplements to be less irritable. Thus,keeping in view that the project being a formidable one to be implemented in widely scattered communities ranging from 100 to about 5000 population, with existing health facilities ranging from a health post to a hospital, provided by the respective managements,they

collected sufficient evidence of the usefulness of a comprehensive health prgramme in improving plantation productivity.

The specific objective of the CLWS was to implement the following programmes through each of the health facilities available at the plantations which were members of UPASI; also another major objective was to persuade managements which did not provide health services, to provide health facilities to implement these programmes. The programmes sought to be implemented were as follows:

i) To implement appropriate safe water supply and sewage systems within a context of a variety of sources of water on the plantations, namely streams, springs, rivers, tanks, etc. and variable size of the isolated plantation communities.

ii) To educate workers and families, especially female plantation workers on health care, nutrition, hygiene, maternal and child health, and family planning.

iii) To implement a comprehensive MCH programme and provide family planning services.

iv) Treatment of common illnesses.

PROCESS OF PROJECT IMPLEMENTATION

The project evolved gradually both in terms of the methodology to be employed to achieve the objectives, and in terms of extending the coverage for the CLWS which has extended from an initial population of 5000 in 1971, which increased to 80,000 in 1972, and then to nearly 2.5 lakhs in 1984. The project has been implemented with the *managements as providers of health services, health personnel as providers of skills, workers and their dependents as consumers.*

UPASI's influence with the plantation managements had its roots in the following factors:

Besides health planning advice to its members, UPASI also provides training in agriculture, technological advances, marketing and other infrastructural inputs

for the benefit of planters in the plantation business. Thus UPASI wields considerable influence amongst its members.

Dr Rahamathulla, evolved the Comprehensive Labour Welfare Scheme in its current form , on behalf of the Association and represents the Association. With her team of CLWS workers, she was able to convert many of the curative and promotive health

units, by training the medical officers to become managers of health services including sanitation and drinking water supply. In plantations where the plantation managements or the medical establishment did not take well to these changes, the CLWS workers worked independently, taking on the task of MCH, family planning motivation and promotion, advice for sanitation and safe drinking water supply, etc., themselves. Gradually by a process of example and persuasion by the CLWS leader, Dr Rahamutlla, by 1985, the medical establishments in about 42% of the UPASI's member plantations could be converted into health establishments, rather than, merely providing clinical services.

One CLWS team is given the responsibility of one plantation area and consists of Project Leader, and six staff, equipped with some audiovisual equipments and a vehicle. The CLWS teams functioned under the leadership of the project chief Dr Rahamatulla.Each planting district may have about 50,000 to one lakh target population.

The process of rendering the services underwent many changes, and finally arrived at the concept of Link Workers. Motivated young women and men from the community who had some free time were identified and trained to be the Link between the medical team controlled by the management, and the community. These men and women are completely voluntary, employed on the plantation, and are trained, motivated and constantly in touch with the main hospital or health post for technical guidance.

These Link Workers in their leisure time in the evenings, work among about twenty families around their residence. About 60% of the Link Workers are female and they predominantly focus on MCH and family planning, while the male Link Workers are able to service the overall needs of environmental health and sanitation. In all these activities they are given supportive guidance and equipment, e.g. health education materials, training on how to lead the worker's discussions at the Leisure Clubs towards health topics, to pick up talking points with housewives to educate them on MCH and family planning during informal neighbourly contact with the families.

With the implementation and extension of the project, the present health infrastructure functioning under the Comprehensive Health Schemes is as follows:

Estates with less than 300 workers are provided with a health aid post, staffed by a compounder or nurse. Those with 300 to 700 workers have a dispensary with a resident nurse or compounder, and a visiting doctor. Those with 700 to one thousand workers, have a hospital with a resident medical officer, a staff nurse, two midwives, one compounder, and supportive staff. Large plantations with more than one thousand workers have a full fledged hospital with two to three doctors, five to six staff nurses, six to eight midwives and several other staff, as well as X-ray and laboratory facilities. Bed strength is worked out on a

basis of fifteen per thousand workers (which, taking families into consideration, may work out to five beds per thousand population).

ACTIVITIES

The activities of the UPASI-CLWS Project are carried out at two levels.

A. At the UPASI-CLWS level:

1. The UPASI-CLWS teams are headed by the Project incharge who is also the Medical Advisor. The Headquarter arranges for train ing and reorientation of medical officers as health managers to build up their health team. In addition, in areas where the plantation managements/medical staff did not take up the CLWS responsibilities, the CLWS directly organizes the community link workers and keeps the Link Workers Scheme going parallel to the medical establishment of the management. Subsequently when the persuasion and education by the leadership of the UPASI and the CLWS results in change of attitude, these medical doctors, nurses or pharmacists are trained to lead the CLWS scheme in their area and the responsibilities are handed over to them. After this the CLWS team moves on to a new area to begin the process again.

2. In consultation with the respective plantations, suitable models are evolved for implementing a sanitary system and protecting the drinking water supply. These models are provided to the plantation health establishments for implementation on their establishment.

B. At the Estate Management Level - Health Post/Hospital

Curative services, antenatal checkup, immunization services, growth monitoring of children, monthly meetings with Link Workers to strengthen their knowledge and functioning in the community, organization for maintaining safe drinking water supply, are some of the services provided by the health facilities.

C. At the Community Level

At the community level the Link Workers take part in the actual implementation of safe drinking water supply and environmental sanitation, carry out health education of workers and families, education, and motivation of mothers for participation in MCH programmes and family planning, Link Workers during their informal contact with families around their residence communicate those messages, lead discussions at Mothers Clubs, Workers Recreation Clubs,etc. , to gain the community's participation in these programmes.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The UPASI-CLWS Project functions under the dynamic team leadership of Dr(Mrs) V Rahamatulla, the Medical Advisor, and Mr B Sivaram, the Secretary of UPASI. Dr Rahamatulla provides the leadership and guidance in technical aspects and Mr Sivaram provides the UPASI leadership inputs required, to strategically motivate the plantation managements to implement the scheme.

There are five CLWS teams under the Medical Advisor, each consisting of one project leader and six staff. They are formally appointed for the project.

The collaborating medical teams controlled by the individual estate managements at the plantations actually implement the scheme. The grass root level work is carried out by about 3800 Link Workers spread out in the plantations, each worker serving about twenty families.

The top level leadership ois chiefly concerned with extending the scope of the project by motivation and persuasion of member planters of South India, and with providing training and guidance to those who accept it. The middle level leadership for the health activities is provided by the medical officers of the plantations who are trained in managerial skills to mobilize the community for MCH, family planning, environmental health and San station through the Link Workers. Within the community, the unpaid voluntary Link Workers, who serve as a Link between the health service and the community assume leadership roles to guide the families under their care for better health, especially maternal and child health and family planning

CLWS HQ Team
1 Medical Advisor
1 Medical Officer
1 Health Education Officer
1 Social Worker

UPASI -CLWS Establishment

CLWS District Team
1 Team Leader
6 Project Staff(Five teams)

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Plantation Hospital/ Dispensary/health post
(Under Estate Managements)

Link Workers from the Community
(Voluntary)

PROCESS OF COMMUNITY PARTICIPATION

The process of community participation is seen from the following:1. Three thousand eight hundred link workers - 60% female and 40% male, who are entirely voluntary take charge of health education and promotion of MCH and family planning in the total population of about two and half lakhs. In their leisure hours they visit the families, attend Mother's Clubs, Workmen's Recreation Clubs and other informal groups in order to guide the conversation to topics on health and educate the people on health. The Link Workers register expectant mothers at clinics, ensure regular attendance for antenatal checkup and immunization of children, and impart health education on Oral Rehydration therapy, nutrition, etc. Male link workers chiefly work for environmental sanitation, and protection of drinking water sources.

2. The community avails the family planning and the MCH services to such an extent that the quality of life and contraception prevalence rate among them has improved remarkably.

RESULTS

The results of the Comprehensive Labour Welfare Scheme have been as follows:

The crude birth rate has fallen from 42.6 per 1000 population in 1971 to 21 pear 1000 in 1985; the crude death rate has fallen from 9.4 per 1000 in 1971 to 2.4 per thousand in 1985; infant mortality rate has fallen from 119 per thousand live births in 1971 to 47.6 per thousand live births in 1985. The contraception rate has increased from 9.5% of eligible couples practicing family planning in 1985; registration for antenatal care and tetanus toxoid coverage are now to the tune of 98% from a low figure of 27% previously. The average birth weight of infants has gone up from 2.2 to 3 kgs. 85% of the population receives chlorinated water supply. Diarrhoea rates have gone down sharply and immunization coverage among children was very high in 1985 (98%) as compared with very poor immunization coverage in 1973. Health has become a way of life on the plantations where the project is implemented.

COLLABORATION AND CONFLICTS

In the plantation sector each estate runs its health post independently, and the CLWS Scheme has been added to a previously functioning statutory health service. The CLWS scheme is financially supported in part by the Government of India and largely implemented through the estate hospitals. Therefore, generally there has not been much ocassion for conflict with Governmental agencies.

One of the professed goals of the UPASI in implementing CLWS was, to implement family planning vigorously. So the Government of India actively gave all the required support, including financial, to implement the Scheme.

Initially conflict was experienced with the plantation managements while persuading them to make the investment on workers health. Subsequently, however, as the managements gradually became convinced of the utility of the scheme for the overall profitability and the spirit of welfare, they began to implement the Scheme.

Initially conflict was experienced with the community. This was due to the labourer's resentment to the purely family planning oriented incentive even before 1971. In 1971, under the CLWS-US-AID sponsored scheme, the No Birth Bonus Scheme was introduced. The tendency of the workers was to view with suspicion employers' involvement costs, and not a reflection of their genuine concern for workers. However, the incentive-based nature of the "No Birth Bonus Scheme", and the subsequent launching of comprehensive labour welfare for health education, child survival and better quality of life dissipated this mistrust. Subsequently the cooperation and participation of the community was ensured.

FINANCIALRESOURCES

The annual operational budget of the UPASI-CLWS comes to about rupees three lakhs. Plantation managements themselves bear the cost of implementing the health and welfare programme. Since the UPASI is an association of planters,

the UPASI establishment expenditure is largely met from contributions of the member plantations with some grant from the Government of India. In addition, however, the statutory requirements as per the Plantations Act entails substantial expenditure by the estate managements to provide health services. Overall, the annual percapita health expenditure by the managements amounts to Rs.130-140 per capita (as compared with an estimated Rs.80/- per capita by the Governments on general population as opined by Dr Rahamutalla).

FACTORS IN THE SUCCESS OF THE PROJECT

The process of change in the health status and family planning acceptance of the plantation of workers was based on a strategy of training medical and paramedical professionals to become managers of health of the community. This change was initiated by a planned propagation of the philosophy, that merely a statutory expenditure, but actually a long term investment which leads to higher productivity of the workers and therefore high profits for the plantation. The medical establishment being in the employ of plantation managements could be transformed into change agents from the UPASI Headquarters. Thus the factors responsible for successful community participation in this health scheme in the organized sector can be summarized as follows:

1. *Thw ample budgetary resources and medical infrastructure which are largely provided as per statutory requirements is one of the major strengths of the UPASI.* The medical infrastructure as described in section III is unique to the plantation sector and provided a strong base which to carry out the programme.

2. *The management were provided with a clear perception that investment in health of the workers is a productive long term investment which would ultimately result in better productivity of the worker and profitability of the plantation.* These effort was aided by the health related productivity research undertaken by UPASI at the start of the project.

3. *Clear line of control between the estate managements which took the decision to implement the CLWS and their respective medical establishment which are directly in the employ of the estate.*

4. *The captive population covered under the CLWS, was another strength of the programme.* Since most of the worker families were located in isolated small plantations and the workers were permanent workers, this led to long term interaction and effect of the Scheme on health practices of the population.

5. *The strategy of taking the workers into confidence, convincing them of the benefits, and enlisting entirely unpaid voluntary services from the community itself independent of the management in the form of Link Workers to work towards the objectives of the CLWS, was a major factor in creating such a rapid health change in the community.*

6. *Stability and commitment of the top management of UPASI*: The association activities and direction are led by the Secretary Mr B Sivaram, who has been in that position for a long time and enjoys high degree of autonomy in functioning. The association is committed to health and development of the workers and their families.

7. The leadership of Dr Rahamatulla, who assumed the responsibilities of propagating the scheme among independent plantations, spread over three states was a major factor. She provided the required ongoing support and training for the medical establishments of the plantations to implement the scheme.

8. The relatively good income of the plantation workers as well as other management sponsored welfare measures such as child creches, leisure clubs, etc., promoted a certain basic economic satisfaction, which could facilitate introduction of health practices and create demand for services from within the community.

LEARNINGS FROM THE PROJECT

1.The per capita expenditure on health of industrial workers in the country is relatively high compared with the general population. The characteristics and situation of industrial workers in the organized sector, are also largely similar to those of plantation workers covered by UPASI. Thus it is possible that a similar model, if implemented among industrial workers, could result in comparable results.

2. Considering the replicability of the process in other situations and in the general population, the factors which need to be considered are the high investment per capita which is achieved owing to the liberal statutory requirements and high profitability of the plantation sector, remarkable provision of health staff and bed strength. These factors peculiar to the plantation workers make it difficult to expect that, in the general population with existing resources and expenditure on health a similar change achieved within such a short time.

3. The success of the project has shown now, with a marginal increase of expenditure (of CLWS staff and maintenance costs), the entire huge expenditure which was being incurred by the estate managements for curative work, with little change in the health status of the beneficiaries, could be productively channelised into preventive activities with remarkable changes in health and family welfare status of the beneficiary population. This points out how a marginal addition of few committed workers and development of human resources, we can achieve remarkable change by the utilization of the same health budget of a group for long term benefits.

Case Study: XVII

SULABH INTERNATIONAL - AN ENVIRONMENTAL SANITATION MISSION

This is a case study of a national environmental sanitation. In 1970, Sulabh Trust was established by the pioneering efforts of Dr Bindeshwar Pathak who was inspired Mahatma Gandhi's call to end the inhuman system of sanitation prevalent in m any towns and cities of India. The dry latrine system (which is still widely prevalent) requires scavengers to carry night soil on their heads. To end this inhuman practice, it requires an alternative affordable, low cost system of sanitation, acceptable to the community which has been accustomed to the age old practice through centuries. This requires the people's participation in the sanitation programme which has to be a social programme, not merely a construction and investment programme. This aspect forms the focus of Sulabh's philosophy and activities. The following is an account of the process of enlisting community participation on a nation-wide scale in the environmental sanitation mission of Sulabh.

THE PROJECT: PHILOSOPHY, BEGINNING AND OBJECTIVES

The philosophy of the project is to translate Mahatma Gandhi's ideal of liberating scavengers from the inhuman practice of carrying night soil on their heads, into a reality. However, this is closely related to sanitation in urban areas. So necessarily, the scheme to liberate scavengers, had to be through an alternative system of sanitation.

With this end in view, Dr Pathak experimented with previous models of the alternative systems to the service latrine, i.e. the trench latrine and dugwell latrine, to modify them for better practicability.

The Pour Flush water seal latrine was designed which is low cost (cost ranging from Rs.700 - Rs.2000/-), requiring only 1 1/2 to 2 litres of water for flushing,without need for sewerage system, and , without need for scavengers to remove the excreta (which is stored in two pits, one in use, the other closed which composts the faecal matter into harmless manure in a period of two years). Besides, it is free from problem of foul smell and flies, and would be accepted by households to be located adjacent to their houses. In addition, modifications to suit different types of soil, varying percolation factors, high water table, etc. would be made.

Once this acceptable design was developed and made operational, Dr Pathak, with his band of dedicated workers started popularizing it with the government for implementation, to begin with, in Patna and other towns of Bihar. As the acceptability of the system became evident in several towns of Bihar, the Sulabh International expanded its scope to other states. The scope of the mission was expanded to (i) rehabilitate the scavengers thus relieved from this occupation into other occupations and (ii) to implement this low cost sanitation in rural areas too, suited to the rural economic conditions.

The main objectives of the organization are as follows:

1. Restoration of human dignity to the underprivileged by raising their status and bringing about transformation in society.

2. Prevention of environmental pollution and promoting ecology, health and hygiene

3. To harness non-conventional energy sources from human waste and procure manure for the fields and save fuel and forest.

4. Creating new employment avenues by training agents of change for rural development

5. Housing for all

6. Diffusion of innovations, education and motivation through mass communication and

7. Promoting consultancy, research and development in technical and social fields

PROCESS OF PROJECT IMPLEMENTATION AND ACTIVITIES

The Sulabh International essentially carries a mission of implementing an alternative viable system of sanitation in towns and villages of India to end the existing dry latrine system of sanitation. This is in line with the professed commitment of the Government of India to end the practice of carrying night soil on the head, which is expressed by the Protection of Civil Rights Act of 1955, by which carrying night soil on the head is an offense. Ample budgetary allocations have been made since Independence towards this goal under each successive Five Year Plan. The Sulabh International executes its sanitation mission, utilizing budgetary allocations in states, towns and villages where it is able to persuade the governments/local bodies to take up the project.

To achieve the objectives, Dr Bindeshwar Pathak with a group of like minded engineers, doctors, etc. who were members of Sulabh Trust, motivated the Government of Bihar in 1969, to entrust Sulabh International with the task of converting the dry latrine system of Patna City (and later on other towns) into the pourflush water seal type. Sulabh thus executes what is essentially a Government programme, making it accessible to the people and administrators by health education.

The Government of India, under the Ministry of Social Welfare and Public Works, allocates a substantial budget in the Five Year Plans for sanitation systems to replace the dry latrine system. 50% of the amount has to be contributed by the State Government or Municipal body for executing the scheme . Sulabh International motivates the State Government administrators and Municipal body administrators to undertake sanitation in a phased manner in their area. In return, Sulabh undertakes, not only to execute the entire construction taking into account local conditions, costs, etc. but also to motivate the community to use them and provides subsequent service in case of any problem in the system. The organization charges a fee of 20% of the project cost towards execution and service charges. The activities of Sulabh International are as follows:

1. The Household Sanitation Programme

The organization executes the sanitation programme not as a construction programme to construct latrines(which frequently ends up in failure of the community to use it for one reason or the other) but, as a social programme with the ultimate objective of utilization of the latrines by the community and the conse quent liberation of scavengers.

The Executive Chairman of each State branch is responsible for execution of sanitation projects in the State. He is in constant touch with the concerned state Housing and Urban Development Department, the municipal bodies of the towns of the State and panchayats to motivate them and finalize the areas to be taken up under the scheme. Then according to the work load, sufficient number of civil engineers and supervisory personnel are recruited (or may be transferred from another state where projects have been completed and staff are free). The project staff go to the town/village/study the area,soil, water table and other factors, contact the local people-ranging from people's representatives to the individual households, to discuss the system, motivate them and educate them on the ill-effects of poor sanitation on health. Then the construction is executed with local labour. Following installation, the Sulabh Organization keeps in touch with the households to service the facility in case of any problem.

2. The Sulabh Community Toilets Complex Programme

In order to cater to the needs of floating populations of towns, Sulabh complexes are constructed. The complex provides toilet and bath facility to consumers on pay-and-use basis with provision of soap powder for maintenance of hygiene of the consumer and the toilet. (Women and beggars are allowed to use it free of cost.) The revenue thus obtained is used to pay remuneration for the volunteers designated as "Caretakers", for the sweepers, lighting and water supply cost.

3. Training programmes have been initiated at their research institution at Patna for volunteers and others who would execute suitable modifications of this sanitation system. They are trained in masonry, execution, and other aspects, to be able to independently take up sanitation projects in the country.

4. An institute for training for rehabilitation of scavengers in alternative occupations was established through which, scavengers relieved from their traditional occupation are trained at trades like mechanics, driving, carpentry, etc., and their wards are also trained in tailoring,etc. In addition, most of the relieved scavengers were appointed as street sweepers and other jobs under the Corporations, municipalities, State Governments, etc.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

The organizational structure consists of the headquarters functioning at New Delhi and thirteen State Branches functioning at Patna, Bangalore, Bhopal, Bombay, Bhubaneshwar, Agartala, Calcutta, Lucknow, Jaipur, Madras, Jammu and Kashmir,Ahmedabad and Hyderabad. The Sulabh International Institute of Technical Research and Consultancy and the Sulabh International Institute of Social Work carry out research and development in low cost sanitation, biogas, and related fields, provide consultancy services to states and local authorities

to undertake training and sociology research. The leadership to the organization is provided by Dr Bindeshwar Pathak who is the Founder and Chief Patron working in an honorary capacity.

1.Project Execution Staff

At each State Branch, an Executive Chairman functions for the objectives of the Trust with a full-fledged engineering and masonry department, and an administrative wing supported by health and social workers. The number working in each state varies with the work load, staff moves from state to state depending upon the work load.

2.Maintenance Staff for Sulabh Complexes

The work force consists entirely of voluntary social workers, who were drawn to the crusade and who work on projects widely spread over the entire country, manning and maintaining the Sulabh Shauchalaya Complexes established throughout the country. Promoting and implementing the Sulabh Shauchalaya Schemes for community toilets in urban and rural areas, schools, selected slums is one of the major functions of the social workers. Sulabh Complexes are under the administrative control of the State Headquarters under the Executive Chairman, who adminis ters finances, placement of staff and other activities.

Totally at present, about 20,000 persons , 3000 engineers including scientists, action sociologists, sanitarian workers and other staff are working under the scheme. It is expected that with the rapid expansion of the programme, by the year 1995, about two lakh individuals will be working in the system, since the Sulabh Shauchalayas are economically self sustaining units, and the execution charges charged by Sulabh sustains the project execution staff.

PROCESS OF COMMUNITY PARTICIPATION

Community participation in the sanitation crusade of the organization can be identified at two levels - at the macro level and the micro level.

A.Participation at the Macro Level

Elected governments of the people actively solicit the professional collaboration of the Sulabh organization to change the system of sanitation in the community. The leadership and members of the Organization present the model to the decision makers in the towns, villages, and organizations like schools etc. It is the community organization (whether State Governments, municipal bodies, or other organizations) who solicit the assistance of Sulabh to set up the facilities.

B.Participation at the Micro-level

1.Utilization of the household latrines: Households provided with latrines use the facility and have thus contributed to the liberation of scavengers.

2. Sulabh Complexes: The set up of the Sulabh Complexes being a financially viable self sustaining system, the utilization by the community , decides whether it would be a success or not. All over the country wherever it has been installed, the utilization by the local community with payment for the utility, has resulted

in maintenance remuneration for the voluntary workers manning the facility, finance required for local labour to maintain cleanliness, lighting, water requirement, etc.

ii) The continued clean maintenance of the facilities wherever started, and the continued recruitment of volunteers into the organization to execute the sanitation works and to man newly installed similar facilities all over the country, expected to reach a figure of about two lakhs by 1995, is evidence of the community's participation in the scheme.

3. Participation in training for execution of sanitary projects: About 27,000 persons in Bihar have been enrolled in training programme launched by the organization to be trained in the skills of rural and urban sanitation. They are expected to become self-employed or work with Sulabh, in the sanitation crusade, in the country.

RESULTS

The change initiated across the country in the sanitaion system is based on the *commitment and activities of the organization towards sanitation as a social programme, whereas sanitation programme is viewed by the Government as a construction programme.* Under the Sulabh Organization, the construction programme has been combined with contact with the people to ensure use of the facilities.

The activities of the Sulabh International has resulted in the following:

i) Fifteen towns of Bihar have been declared scavenger-free by the conversion of 1.25 lakh dry latrines to Sulabh Shauchalayas. Thirty more towns are on the verge of become scavenger free.

ii) Across the country, in towns and cities of India, more than 5.4 lakh latrines of the pour-flush type designed by Sulabh, have been constructed and are in use.

iii) About 2000 scavengers liberated so far, have been provided with alternative employment in different trades such as vehicle mechanic, driving, tailoring, etc.

iv) Self sustaining Sulabh Complexes manned round the clock provide toilet and bath facilities in 445 towns and cities in India.

v) This model of sanitation has been implemented in about 3000 schools of Bihar, both urban and rural.

vi) A massive programme for training rural community-based persons like school teachers, engineers, social workers and masons in installation of suitable rural sanitary latrines, has been taken up with the assistance of the Bihar State and Central Government, UNICEF, UNDP and other State Governments.

vii) The design and methodologies developed have been disseminated to South East Asian, Latin American and African Countries through UNICEF and UNDP.

COLABORATION AND CONFLICTS

Sanitation is a State responsibility and the strategy of the Sulabh International is to execute community sanitation through individual, community and governmental acceptance of this method of sanitation. This has made for a natural ground for collaboration between Sulabh International, Central Government, State Governments, municipal bodies and organizations, to install the type of latrines suitable for the local conditions and budget.

The Department of Non-conventional Energy Sources of the Government of India, lends full financial support for continued research, to improve upon the innovative system developed by the organization, to obtain bio-gas purely from night soil of community toilets, for street lighting in urban areas and energy for irrigation in rural areas.

With financial grants from the Government of Bihar, and Government of India, the Sulabh Institute for Rehabilitation and Training has been started where more than 2000 scavengers and their families have been rehabilitated into alternative occupations like masonry, latrine pan manufacture, tailoring, driving, mechanics, etc. Grants are obtained from Government for running of the Institute Programmes.

With Government of India support, the Sulabh Institute of Research and Training was set up. All training programmes for volunteers to train masons engineers, etc., are conducted the help of with government grants.

Generally there has been no conflict with the community where the system was installed or with the government.

FINANCIALRESOURCES

The organization does not receive adhoc grants from any source whether governmental, foreign donors, or international agencies. The maintenance, promotional and research activities of the organization are met from specific budgets for the training and research programmes, and supervision charges of 15-20 percent of the capital cost of construction, charged from the organization, sponsoring or installing the latrine facility.

Besides, the volunteers who form the work force at the Sulabh Complex level (numbering more than 2000), are maintained by the income generated at the Sulabh Complexes, from the payment of twenty paise by each user of the toilet or bath facility.

FACTORS IN THE SUCCESS OF THE PROJECT

The factors which have influenced the success of the Project are as follows:

i) The leadership provided by Dr Bindeshwar Pathak in organizing a core group to lead the crusade to persuade governments, local bodies, communities and individuals to accept the safe and humane system of sanitation.

ii) The objective - oriented activities of the Sulabh International which is committed to liberating scavengers and not merely to construct latrines. This has made the Sulabh programme of sanitation a social programme executed for community acceptance and use of the system, rather than a construction programme.

iii) The clean, acceptable and affordable system of sanitation to suit the socioeconomic conditions was an important factor for its acceptance.

iv) The felt need of the community for a system of sanitation and privacy for excretion in the urban areas, where the people do not have free access to the open spaces available in rural areas, was another factor which promoted easy acceptance of this sanitation system.

v) The avowed commitment of the Government of India to provide sanitation and eradicate untouchability, which promoted financing of this technology.

vi) Systematic budgetary allocations under each Five Year Plan for sanitation, which could be utilized for the purpose.

Case Study: 18

HYDERABAD SLUM IMPROVEMENT PROJECT - MUNICIPAL CORPORATION OF HYDERABAD

This Project was started in 1980 by the Municipal Corporation of Hyderabad following an experience of 15 years of sporadic slum improvement and community organization activity in 215 slums. Initially from 1980-83, the HSIP (Phase I) was a UNICEF assisted project started as a part of the Urban Community Development Department(UCD). From 1983 onwards, the project has been assisted by the Overseas Development Administration (UK) with a view to ensure that all the 662 slums (of which 455 are recognised slums) of Hyderabad are covered systematically in a phased manner. During these phases, -- Phase II and III, the project has been administratively bifurcated from the UCD Department retaining a few functionaries from the department.

THE COMMUNITY SERVED

The slum community served by the UCD Department consists of about one lakh seventy thousand families or approximately 8.5 lakh population residing in 662 slums of the twin cities of Hyderabad and Secunderabad. As expected, the slum population covered has been changing. From an initial population coverage of 50,000 of one ward with about 12,000 slum population covered, it has been gradually increasing with expansion of the project. Since 1977, the entire slum population of the recognised slums have been brought under UCD coverage. During the Hyderabad Slum Improvement Phase II and III started with ODA assistance, unrecognised slums are also included. Also with the years, the stress on working with the economically weaker sections of the society has been increasing. During the 1960's the focus was on the slum population as well as the lower income groups.By 1977, faced with the rapidly increasing slum population and critical situation in the slums, the UCD department was wholly concentrating on schemes and programmes for the slum population. Unlike the slums of Bombay or Calcutta, where the problem was chiefly that of scarcity of land and very high price of land beyond the reach of slum dwellers, the main problem of the slums in Hyderabad was one of acute poverty.

The family income of the beneficiaries in the year 1980 was ranging between Rs.250/- to Rs.400/- . 90% of the slum dwellers are unskilled daily wage earners either engaged in building construction, porters, rickshaw pullers, petty businessmen and maid servants. About 10% were skilled or semi skilled labourers engaged in beedi making, flower garlanding, masons, carpenters, tin smiths, blacksmiths, etc. The literacy level is only about 16% with a range of 11-30%. The average family size is quite high i.e 7 per household. It ranges between 7-9 per family in the old city and about 6 per family in the remaining slums.

About 300 of the 455 recognised slums are as old as 40 years, 73 between 15 and 20 years, and the remaining 52 slums are between 10-15 years old.

One hundred and thirty seven slums are on government land or quasi government lands of which 20 were categorized as objectionable in view of their location in the low lying areas, location on road sides and in violation of the

master plan of the city Keeping in view the Andhra Government's liberal urban policy, the families living on unobjectionable slums could be readily granted pattas without litigation or need for negotiation with private land owners. The slum communities living in the objectionable slums had to be relocated with their consent and active participation, whereas the slums on the non-objectionable land were to be improved and their ownership regularized. (This is being done in a phased manner with the assistance of the UCD department).

The health status of this population was very poor. 46% of deliveries took place at homes, and, in the absence of a dai training system, all of these would be more or less with untrained birth attendants. 60% of child deaths took place before one year, and 62% of the infant deaths occurred in the first month thus showing that poor antenatal and intranatal care were responsible for substantial deaths. The immunization coverage in 1983 was estimated to be about 20-25%. Family planning acceptance was low. On the other hand, the maternal and child welfare programmes including Balwadi centres, supplementary feeding of children and lactating mothers, were fairly strong due to stress on these aspects and on community development work by the UCD Department since 1965.

By 1980 when the Hyderabad Slum Improvement Project took off, there was a substantial network of grass root level organizations in the slums, owing to the community development work of the UCD functionaries since 1967. In 223 slums there were Basti Development Committees; 135 slums had youth organizations and there were 99 Mahila Mandals. In all about 9,000 members of these organizations were already actively working with the UCD department in the sporadic self-help programmes organized by the UCD based on the felt needs of the people.

Thus when the HSIP was initiated as a systematic slum improvement programme, the slum population though poor, had been exposed to and active in the self-help, felt-need based pro grammes organized by the UCD department.

THE PROJECT - PHILOSOPHY, BEGINNING AND OBJECTIVES

A.Philosophy and Beginnings of the Project

The HSIP was initiated in 1980 based on the experiences of 15 years of urban community development work by the Municipal Corporation in the slums.

The UCD department itself started as an urban community development project based on the detailed recommendations of the Third Five Year Plan of the Government of India. This project was started as one of 22 such pilot projects in the cities having Municipal Corporations, with a view to create a sense of social coherence, bring about civic consciousness, motivate the people to improve their conditions of life, particularly the social and physical environment on a self-help basis, and to ensure the full utilization of the services being provided by the government or other organizations. To achieve these objectives, and also to create a set of staff to act as a liaison, the UCD department was created under the leadership of Dr. G.Surya Rao, Project Officer and eight community organizers. UCD staff were expected to estab lish contacts with the community, identify the local leaders and assist them in getting the services provided by the Corporation, banks or other agencies. Thus initially, the objectives of the UCD department were chiefly to create awareness among the people of the need for

healthy living, organize slum associations and Mahila Mandals, utilize these associations to mobilize the commu nity to accept and also participate in the developmental and socio-economic programmes.

However, with the introduction of the Hyderabad Slum Improvement Project, particularly Phase II and III with ODA assistance, the slums were systematically taken up in a big way for environment improvement, health and socio-economic inputs, physical infrastructure and other activities, in a phased and timebound manner. *An important difference in the developmental dynamics prior to and during the HSIP phase II and III is that, although the objectives of the HSIP are aimed towards slum improvement, these objectives have not been arrived at by a consultation and consensus with each of the slum communities.* Under the objectives of the HSIP, substantial inputs are expected to be made and the community is expected to sustain and participate in these inputs.

B.Objectives

With almost ten years of community development work by community organizers in the slums, it was felt both by the UCD department as well as the slum population, that the sporadic development activity and community organization alone cannot produce lasting change in health and quality of life unless all the slums are systematically covered for health, physical infrastructure including civic amenities, housing, socio-economic programmes and educational programmes, and there could not be much impact by sporadic patchy improvements. With this realization the HSIP took shape. The broad objectives of the HSIP is to develop all the slums in the city in a phased manner, and subsequently, hand over the developed slums to the UCD department for maintenance and post-project sustenance through community involvement. The general objectives of the HSIP are as follows :

1.Improvement of environment in the project slums by implementing various infrastructure development programmes.

2.Developing civic infrastructure within the slum in a manner accessible to the lowest percentile of the economic groups.

3.Improving the health and nutrition status of the slum communities by implementing suitable programmes such as immunization, vitamin 'A' & folic acid, drug supplementaries, health and nutrition education, etc., with particular emphasis on women and children.

4.Improving the skills of the eligible target group by taking up specific programmes of skill upgradation and introducing new skills, convergence of various State Government Economic Support Programmes like Bank Loans, etc.,

5.Providing health infrastructure in a manner accessible to the people to reduce the infant and maternal mortality and morbidity rate and by taking up suitable intervention programmes.

6.Improvement of literacy rate by taking up adult literacy programme.

7.Improvement of child care facilities by way of preschool literacy, creches, etc.,

8.Strengthening the reporting system of vital statistics.

9 Promoting community cohesiveness, mutual understanding and national integration

10. Promoting community participation in programmes of Government and local authorities.

11. Strengthening the efficiency of delivery of civic services through peoples participation.

12. Improvement of the quality of life of the slum communities.

13. Building up a sense of self-reliance amongst the slum communities.

NATURE OF THE PROJECT AND SCOPE OF ACTIVITIES - PHASES

The Hyderabad Slum Improvement Project has four main components :

1. Physical Infrastructure and Engineering component

2. Health Inputs

3. Literacy promotion

4. Economic support programmes

In addition to activities towards these main objectives, the project functionaries both from the Corporation side and the community side, act as a liaison for housing and the developmental programmes of other agencies such as SC, ST and BC Corporations, and the Lead Bank which are channelised through the project.

The improvement of the slums to a desirable level is being carried out in three phases. During Phase-I, the Municipal Corporation through its own funds, supplemented by the State Government grant-in-aid and UNICEF assistance, took up the activities of environmental sanitation, water and physical improvement activities, housing, shelter and slum upgrading, health and family welfare activities supplementary feeding programmes; recreational and cultural activities and youth programes; educational activities including preschool and adult literacy; vocational training and educational activities; economic support activities; construction of community halls; these activities were to be undertaken in 228 slums but could be completed only in 142 slums benefiting about 19,400 families (1,22,000 population approximately). The remaining slums could not be improved with these programmes for want of funds.

During Phase-II the same activities as Phase-I were undertaken in 210 slums with ODA assistance. During Phase-II the slum population of 2-6 lakhs, were covered. During Phase-III a total of 300 slums with 4,6 lakhs population (about 76,000 families) are being covered for the above services.

PROCESS OF PROJECT IMPLEMENTATION AND COMMUNITY PARTICIPATION

A.Early years of UCD activities - 1965-72

The community development process was started as early as 1967 when the UCD project team of eight community organizers led by the Project Officer took up the task of developing self help, self reliance and community organization attitudes in a slum population of approximately 12,500 in ward no.22 of Hyderabad city. These community organizers went into the slums, tried to identify local leaders who were already existing (religious, social, youth leaders or otherwise), organised meetings with the slum dwellers and began the process of creating awareness about healthy surroundings and shelter improvement, health and nutrition. In the course of these meetings other individuals with initiative were identified to represent the poorest sections, women, the scheduled castes and other backward sections of the slum so as to have the representation of all sections. These people were gradually organized into Basti Development Committees, slum associations, Mahila Mandals, youth organizations and also other informal groups to enable them to take initiative through group identity. Based on these meetings and with consensus of the community the priority problems were identified, which were different in each of the slums. The UCD functionaries then enabled the Corporation to support or take up the priority slum improvement activities such as provision of public water stand posts, street lighting, laying of sewer lines, metal roads, community lavatories etc. The services provided were based on the needs expressed by the people.

The community organizers initiated discussions on shelter improvement, vocational training for youth and women, child care and literacy, economic support programmes, etc, which generated awareness and initiative from the community to actively participate in the initiation and implementation of the housing programme, the vocational training programmes, Balwadis, Special Nutrition Programmes, economic support programmes, etc. The UCD functionaries thus functioned as catalysts to bring out the initiative and participation from the community on the one hand, and to channelise the limited resources of the Corporation into the felt need programmes on the other. Thus wastage of resources was avoided which is the characteristic of uniform top-down approach adopted in most government programmes. For example: if very low income and poor status of women emerged as a priorityissue in a particular slum, the community organizer would guide them to agree upon a suitable vocational training programe such as sewing classes, typing, doll making etc. Following this, it was given as a responsibility to the Mahila Mandals and other local organizations to mobilize rent-free accommodation, in a hut or a house., to mobilize atleast 15-20 women to attend the training, and identify a sewing teacher who would be paid a small honorarium from the Corporation funds. Then the community organizers would approach the Corporation to get the sewing machines sanctioned. Similarly other cottage industries like Lijjat papad and cardboard manufacturing; catering cooperative; motor car driving and other activities are organized. To organize welfare activities such as balwadis, mid-day meal programmes, and the egg feeding programmes, the community organizers took the assistance of the local associations after creating awareness of the need for such services. Following this, it was up to the community to provide the rent-free accommodation, and identify a suitable educated person to be trained as a Balwadi teacher, cook etc. Thus the role of the UCD department has been chiefly to bring out the need for the programmes which generates the community

participation, which in turn results in cutting down the cost of the programme to the Corporation, and at the same time ensures maximum benefit of the programmes to the people.

In the case of creation of community assets, the community organizers have a more challenging role. For example it was found that community halls which were constructed purely by the Municipal Corporation, were poorly maintained and utilized; at the same time the cost was high because all the inputs came from the Corporation side. The community organizers began to educate the people on the need for having a common place for meetings, entertainment, library room, Balwadi activities, vocational training etc. Subsequently, with the help of slum associations they were able to mobilize the skilled and unskilled labourers in the community to provide voluntary labour for the construction of the community halls, while the Corporation provided the materials. On a similar basis about 100 milk booths were also constructed. This resulted in a reduction of cost to the extent of about 20% or more, and at the same time ensured good quality of construction and good maintenance of the buildings. (Infact during a major riot which rocked Hyderabad, there was large scale destruction of community property including few community halls and milk booths. However none of the halls or milk booths constructed by the people were permitted to be destroyed since the community protected these assets). Also, in the case of most of the community halls which have been constructed on this, basis the electricity charges are being paid by the community through the slum associations which raise funds at the rate of Rs.5 to Rs.10 per family per month. Also these community halls have become the nidus for many community activities on a sustained basis, such as locally sustained Balwadis, sewing centres, etc.

The housing programme as a community based programme under UCD, was taken up in 1977 after the total failure of the slum clearance activity. In the case of housing programme under UCD the issues to be resolved are much more complicated since it involves acquiring possession of land, certain amount of give and take by families which have a larger plot, or which are in an objectionable position for forming the layouts, etc. Problems also arise in the case of slums with very high density; everybody needs to be accommodated and mostly not willing to occupy the first or second floors of a building. With the aid of the Basti Committee, promotion of landownership through patta scheme, with the cooperation and assistance of the Corporation engineers, and constructive suggestions by the community on land sharing, layout formation, housing designs, etc., these problems are thrashed out and layouts are informed to accommodate most of the families in the same place. In cases where the slum dwellers are squatting on private land, the UCD department acts as a liaison between the slum dwellers and the landowner to arrive at acceptable solution to both, which results in the land owner giving up the relatively less advantageous portion of the land to the slum dwellers retaining the prime portion; most of the families are then accommodated in the available lands in single or multistoreyed houses. During the period 1977-80, the UCD functionaries acted as a liaison to motivate the banks to provide 80% of the cost of construction of Rs.6,000/- as loan to the slum dwellers. The Municipal Corporation provided a subsidy of Rs.1,000/- and the beneficiary provided the remaining in the form of labour, the salvaged material from the house which is demolished etc. The CO's through the slum Committees also ensure that as far as possible, most of the labour for the construction of all the houses in the layout such as masonry, carpentry, unskilled labour, etc. is provided to each other by the local slum dwellers themselves at a concessional cost to each other. This has resulted in a sense of

fellowship and community spirit among the slum dwellers. Also, since the slum dwellers are involved at every stage - from the stage of formation of an acceptable layout, demolishing and leveling the hutments (which is done by the families themselves), construction of the houses, construction of other civic amenities such as street formation, sewer lines, storm water drains, construction of community toilets, etc., it has been found that illegally selling these houses thus constructed or renting them out, is very uncommon (less than 1% of the houses thus constructed were found to have been sold). The loan repayment rates to the banks were also very high (except in SC layouts or SC families where the local politicians complicated the process by assuring them that the government would waive off the loan for them).

B.Changes in Project Implementation during the HSIP Phase-I (1980-83)

Between 1980-83 when it was felt that a systematic programme covering the Urban Basic Services was required along with housing programme and health inputs The HSIP was formulated as a timebound project to provide all the planned inputs after a systematic survey in the slums taken up under the HSIP. In addition to the engineering and socio-economic programmes, the housing programme was taken up in a big way with the assistance of the Housing and Urban Development Corporation (HUDCO).

It had been observed that the multistoreyed tenements constructed for 2368 families at a cost of Rs.139.43 lakhs upto 1976 under the Slum Clearance Programme, without the active participation of the slum dwellers had turned out to be a total failure. During a survey carried out in 1980 it was found that none of the original allotees were living in these tenements whereas families which had constructed the houses on a self help basis with the active inputs of the UCD department and financed by loans from Banks, were continuing to live in the house constructed. This finding was an eye-opener to the Corporation, which now included the housing programme as an essential part of the UCD activities under the HSIP project. Attracted by the low interest rates and higher loan amount of HUDCO, the source of finance was changed over to HUDCO. Around this time the SC,ST and BC Corporations also became active in the area by granting loans for income generation activities for the weaker sections. With the initiatives of the leadership of the Municipal Corporation the SC,ST and BC Finance Corporations of the Hyderabad District Collectorate got linked up with the UCD activities. The District co-ordination Committee, which is chiefly responsible for channelising the funds of the entire Government for the Economic support Programme for the Weaker Sections, for was taken into confidence by the Corporation. The District Collector who is the Chairman of the Committee, and the UCD Director worked in close coordination to ensure that the loans reached the right beneficiary. The UCD functionaries also identified and arranged training for poor women in sewing and other income generation activities; as a follow up, they arranged the loans from the economic support programme for purchase of sewing machines, petty equipment for papad making, etc.

However, since the HSIP was originally envisaged as a time-bound programme with the need to cover 228 slums within the period of three years, the work was taken up simultaneously by the Engineering Department to execute a pre-planned engineering scheme of inputs; the UCD functionaries continued to be predominantly involved in continuing the community based work, need-based community activities, and socio-economic programmes. The housing programmes were also largely planned on a technical basis by the technical staff

of the Corporation. Also, the housing programme financed by HUDCO, required a lot of specifications, clearances, certification at several stages by the engineers and other formalities, which occupied the time of the technical (engineering) staff of the Corporation.

During this phase, an attempt was made to provide health inputs in response to the felt need of the community. Three Municipal Corporation doctors were spared from the dispensaries, once a week and asked to make a weekly visit to one or two slums to provide curative services. In this manner only 20 slums could be covered and hardly any change was felt by the community with this system. Owing to some degree of psychological resistance from the doctors to visit the slums, frequent lack of vehicles and other logistic problems, the health programme as a community-based programme did not take off during the Phase-I.

C.Development in the HSIP during Phase II (83-84 to 87-88)

In 1983-84 the HSIP assumed a much bigger role in slum development with the assistance of the Overseas Development Administration of the UK Government. ODA assistance was envisaged in two phases, 1983-84 to 1987-88, and 1988-89 to 1991-91 as the HSIP Phase II and III respectively. During these phases the project had a much larger scope and required the simultaneous functioning of large number of functionaries to carry out the different components - physical infrastructure, socio-economic inputs, and literacy programmes, as well as the liaison activity for the housing programmes. All the 662 slums (including 455 identified slums) are envisaged to be covered systematically for all the above slum improvement activities which had previously been found to be highly successful when initiated by the UCD department on a felt-need and self-help basis.

However, to contain cost escalation and to cover the targeted slums in a time-bound manner, targets in terms of all these activities had to be achieved. The budgetary provision had to be spent during that time. Thus the time available to involve the community in the planning and implementation of the programme is minimal or nil , since work had to be started immediately. In order to expedite the activities under each of these programmes, and to undertake the activities on this scale, (covering 210 slums during the HSIP Phase-II and about 300 slums in Phase III), the staff strength of the Engineering Department was increased several fold (vide annexure); 20 health teams were formed, each with an Honorary Doctor, ANM and community health volunteer; a few accessory staff were added to the UCD department. To carry out the literacy programme which envisaged literacy coverage to 1.84 lakh adult population of the selected slums under HSIP Phase III, and preschool literacy for 45,000 preschool children, 600 educated women and men were to be trained as Balwadi or ICDS teachers, health workers, mid-wifery and child care workers.

On the other hand, the number of community organizers (COs) remained the same even though the scope of activity expected to be carried out coverage was extended overnight under the HSIP Phase II and III. During this period they are expected to identify suitable persons to be trained as the community health workers, Balwadi teachers, midwifery, trained child care workers, etc. They are expected to identify suitable persons with the help of the slum associations for vocational training, income generation programme and other economic development activities in the slums, they are expected to perform the liaison

function, for the success of the housing porgramme and other physical infrastructure. In addition a new challenge has emerged with the massive inputs of the HSIP Phase II and III, and that is, the need for preparing the community to participate in the post project sustenance of the physical infrastructure, health infrastructure and literacy programes even after the ODA assistance is terminated.

The COs were previously operating in the slums to create a process of community identification of needs, prioritizing the needs and then enabling them to get the relevant slum development services bit by bit. Whereas under the HSIP Phase II and III, owing to the short time and need to prepare the community for large number of services at the same time, they had to change over their strategy from that of working patiently with slum after slum, to a strategy of, convincing the community to agree to comply for the various slum improvement services being provided under the project. On the other hand, they are expected to also ensure that the community takes up the responsibility to participate and maintain the services and infrastructure created under the project. Thus, during the HSIP Phase II and III there is a certain incompatibility between mode of project implementation and expectation of degree of community participation.

ACTIVITIES

The activities being carried out under the HSIP can be classified as follows.:

A.Community Organization and Creation of Awareness

A major activity under the UCD department is community organization and awareness creation. Each of the community organizers has 3-4 slums attached to him/her. The community organizer goes to the slum, establishes contact with the local leaders; organizes meetings to identify the pressing problems of the slum dwellers; educates them on the programmes available and on the possibility of the slum dwellers improving the situation by themselves; identifies other possible leaders especially among poorer and un-represented sections like the women, SCs, STs etc. Gradually, with the consensus of the community, the Basti Development committees, Mahila Mandals and Youth Organizations are formed. Sporadic activities are organized under the matching grant programme of the UCD department such as Cleanliness Drives, self help libraries and various other activities which strengthens the community organizations and gives them a sense of group identity. Later on the community itself takes up the initiative to utilize these committees for other developmental activities in the slum.

In the initial stages, the community organizer acts as a guide to the Basti Committee and enables them to understand the process of making representations to the Corporation or other agencies for specific services, follow-up of the matter, applications for loans and other activities. He also assists them in taking decisions on community activities and in convening the periodic Basti Committee meetings. The CO helps the members to keep up the enthusiasm to attend the meetings, and keep up the discipline until the system is well established in the slum.

Following this the CO acts as a guide to the committee and moves on to the next slum for intensive activity.

In the ODA intensive slums, the COs are active to educate the community on the programmes to be introduced, bring about the consensus in such matters as, location of the public water stand posts, location of the community toilets, street lights, sewer lines; adjustment in layout formation under the housing programme; formation of groups of approximately 20 members which in turn authorise one or two reliable persons in the group to draw cement, steel and other building materials on their behalf; identifying the suitable persons within the community to be trained as Balwadi teachers, midwives/ANM, child care workers etc.

B.Engineering and Physical Infrastructure Component

Under this component, the following activities are carried out for improvement of the water and environment :

Provision of safe water supply through public water stand posts and tube wells, provision of private water pipe connection in case of households who can afford to provide the internal infrastructure for this; sewage - main and branch sewage lines; inspection chambers for house connections; construction of common septic tanks; low cost sanitation - to share the cost of construction of low cost house lavatory to the extent of 30% from the Project funds the rest being met from the Government of India and beneficiary contribution; construction of community halls of a suitable size based on the population of the slums.

These infrastructural facilities are being created in accordance with the detailed project plans which were drawn up after a survey of the slums selected for implementation.

C.Health

Health programme is chiefly of preventive nature and the focus is on

(i) immunization of children and pregnant mothers, and

(ii) health education to promote good nutrition, personal hygiene and small family awareness. For this purpose 20 health teams have been formed with honorary doctors (selected through the Employment Exchange) and an ANM. In addition, under the HSIP Phase III, suitable persons from the slums are being trained as community health volunteers to mobilize the community to come forward for immunization, health education and curative health services provided by the health centre. The health teams are located at 20 health centres which may be a community hall or a rented building located within the slum. Six slums are attached to each health centre. On an average, doctors are paid a honorarium of Rs.1,500/- each and the ANMs are paid an honorarium of Rs.250/- per month. They work for the slum health programme between 9AM to 1PM. Between 9 and 11 AM they are occupied at the health centre in treatment of minor ailments, health education sessions which are carried out every week, motivation of eligible couples for family planning etc. From 11 AM to 1.00 PM the team visits one slum every day. Thus every slum under the health centre is visited once a week. During the visits to the slum, home visits are done and the following activities are carried out:

i) Motivation of mothers for immunisation of eligible children and pregnant women.

ii) Vitamin A prophylaxis for prevention of blindness.

iii) Iron and folic acid distribution to children and pregnant mothers for prevention of anemia.

iv) Distribution of deworming drugs to children.

v) Family survey, maintenance of family folders and updating family folders for details of family size, immunization, family planning practice and malnutrition.

vi) Growth monitoring of 0-6 year old children.

vii) Health education through family contacts, group contacts and community interaction through local leaders and influential persons in the community.

viii) Registration of births and deaths.

ix) Training of women in balanced diet and food preparation.

x) Immunization of eligible children and women on camp basis.

xi) Identification of dais active in the area to be selected for training.

xii) Motivation of eligible couples for family planning.

D.Economic support Programmes and Income Generation Activities

The economic support programme is the strongest and the oldest programme of the UCD, therefore the best organized programme of the department. The economic support programmes and income generating activities were among the first self-help activities to be taken up by the UCD in collaboration with the slum organizations since this was the most acutely felt need by the slum dwellers.

i. Improvement of Skills

Skills training particularly for women and youth are undertaken through organizing sewing centres, papad making centres, community kitchen gardens, backyard poultry units, doll-making training centres, etc., In addition, training in other skills such as typewriting and shorthand, autorickshaw driving, photography, airconditioning and refrigerator training, T.V and transistor repairs, cardboard boxes manufacturing etc, were started on a self help basis with a very low cost to the UCD department. District Industries Centre provided the staff for some of the training programmes.

ii. Assistance for Procurement of Loans for Income Generation Activities

In addition to skills training, the UCD functionaries liaise with the banks, the SC/ST/BC Finance Corporation of the Hyderabad District Collectorate and the Government Economic Support Programme for the Weaker Sections. Through these agencies suitable loans and grants are channelised to the right beneficiaries for purchase of sewing machines, starting garment manufacturing cooperatives, purchase of petty equipment for starting papad making unit or for air conditioning or T.V repairs, purchase cycle rickshaws, starting backyard poultries, relieving indebtedness to private money lenders operating in the slums, improve petty business such as vegetable or fruit vending. These activities

are taken up as and when the slum dwellers come forward to participate in the activities or express a need for a particular type of activity.

iii) Formation of Cooperatives for Production of Cottage Industry Goods and Marketing

Garment making cooperatives, poultry cooperatives, papad cooperatives, tailoring cooperatives, card board boxes manufacturing cooperatives, etc, have been formed with the help of the slum association. For the marketing of the products the assistance of the national and local voluntary organizations such as Rotary, Lions, Lijjat, etc., is mobilized.

In all the income generation activities, the local basti sahayak and social worker are actively involved under the supervision of the community organizer to identify the right beneficiary and help them sustain the process. The UCD functionaries also exert pressure through the local slum association for the repayment of loans taken from banks and other agencies.

E.Literacy and Education Programme

The UCD department has been actively involved in preschool literacy, adult literacy as well as assisting schooling and vocational education of children from the poorer socio-economic families. Under the HSIP Phase - III the preschool and adult literacy are receiving a concentrated boost. The preschool literacy programmes of the HSIP is linked up with the Special Nutrition Programme of the State Government to also provide nutritious mid-day meal for the children attending the Balwadis and pregnant mothers of the slum.

i)Balwadis for preschool children

Opening Balwadis for child care in the slums has been one of the oldest programmes encouraged by the UCD department. Care of children in the age group 3-6 years, teaching the alphabet; preschool preparation of the children, health education of the mothers in child care and family nutrition, are undertaken at these Balwadis. Most of the Balwadis have been started at the instance of the Mahila Mandals which were organized in the slums by the catalytic activities of the UCD functionaries since 1967. As and when the ICDS scheme is extended to the slum, the Balwadi is converted into a full fledged Anganwadi and handed over to the ICDS functionaries for management. In the absence of community hall in the area (which is the case in 2/3rds of the slums) the venue is finalised in consultation with the community. This venue may be rent free or provided by one of the local slum dwellers at a nominal rent.

ii)Adult Literacy Centres

On the HSIP Phase III, the adult literacy programme is envisaged to cover a total adult population of about 1.84 lakhs in the age group of 20-60 years in the 300 selected slums. Prior to Phase III, all literary centres were started in response to the felt needs but the coverage was not systematic as it is expected to be in Phase III. About 300 adult education centres are being started in the Phase III slums. The persons to be placed as adult education teachers are being selected from among the educated persons of the same slum and paid a honorarium of Rs.100/- per month. The slum communities and leadership are utilized at all the stages of the programme viz., selection of the suitable venue in case community

hall is not available, identification of a suitable for training, and motivating the illiterate slum dwellers to attend the school.

iii) Libraries/Reading Rooms and Community T.V. Sets

The concept of motivating the community to take up the reading rooms and libraries at the community hall or in other rent-free voluntary accommodation provided nearby, has been pursued by the community organizers since the very early phase of UCD activities. The educated persons in the slum are motivated to start the reading room or library to which the Municipal Corporation or Voluntary agencies would be motivated to donate a few books. The responsibility of running these reading rooms and libraries was entrusted to the Basti Welfare Committee or Youth Organizations.

In the 1980's, the television as a mode of education has caught up with the people. The community T.V sets are purchased on a matching grant basis in the slums where pucca community halls are already available. In the case of color T.Vs the community is expected to mobilize Rs.1000/- towards its cost after which the Corporation provides the TV sets paying the remainder as subsidy.

F.Housing

The housing programme as a self-help programme was started from the year 1976. Under this scheme, the community organizers and the slum associations are intensively involved to identify the genuine residents of the slum, to mediate the business with regard to procurement of land ownership, to get the clearance from the town planning and revenue authorities for formation of a layout, relaxation of the rules and norms of town planning, procuring the pattas from the government, getting the families together to agree upon the allocation of sites for the families, adjustment of sites, multistoreyed buildings for families related to each other in case of scarcity of land, agreement among the slum families for the proposed location of the public water stand posts, making joint applications for loans to the funding agency, and the other procedural matters to be attended prior to receiving a loan. The Engineering and Town Planning Departments of the Corporation are involved with production of detailed plans and layouts, providing advice to the slum dwellers on quality of construction and other matters, supervising the constructions to certify the various levels reached for release of each installment of the HUDCO loan, provision of suitable civic amenities such as water supply, drainage and other facilities. The UCD functionaries through their rapport with the slum organizations assist the Municipal Corporation Collection Clerk to mobilize the HUDCO loan repayments from the beneficiaries. Thus, while the UCD functionaries chiefly prepare the people for housing programme and enable them to get the loans from the banks or HUDCO or any other agency, the Engineering Department is chiefly concerned with the technical aspects of the housing programmes in the slums.

In the case of housing loans which were being provided by the banks prior to 1980, the role of the UCD was quite limited, chiefly to create awareness among the community, catalyse the process of enabling the people to apply for and receive the loans. The banks would release loans separately to each beneficiary. For loan recovery, the banks were assisted by the social pressures and activities of the Basti Development Committees.

1. In the case of the loans procured from HUDCO, the role of the Municipal Corporation is much more complex.The UCD Department is concerned with several procedures prior to attaining the sanction for the loans. The Corporation Engineering Department, on the advice of the UCD functionaries negotiates with the HUDCO to relax certain norms of building plans, etc. to suit the local slum condition. The UCD functionaries are also required to form groups of 15-20 families (owners or patta holders) in the slums who in turn select one or two leaders. The Corporation is the intermediary to whom the HUDCO releases the loan, and the Municipal Corporation undertakes responsibility for repayment of the loan. The Corporation purchases the material-cement and steel etc, and releases it stage by stage to the group leaders as and when its engineers supervise the work sites and certify that beneficiaries have brought up the construction to the required level. The house construction as such is undertaken by the individual beneficiaries; substantial technical guidance is provided by the Municipal Corporation Engineers. Since the HUDCO loans are underwritten by the Corporation jointly with the State government, the loan recoveries are made by the revenue branch of the Municipal Corporation through the Loan collection clerks who go to each slum on a specified date to collect the monthly installment.

G. Women and Child Welfare and Cultural Activities

In addition to the regular child welfare activities under the Balwadi Scheme and mid-day meal scheme, sporadic child welfare activities are undertaken in cooperation with the local branches of the Rotary Clubs, Lions Clubs, sporadic welfare programmes of the State Department of Welfare. These include, distribution of free dresses for Harijan children, egg feeding programmes, distribution of school notebooks, medical check up, admission in social welfare hostels, etc.

In addition to women's health promotion activities and the economic support programmes for women indicated in the foregoing paragraphs, several other activities are undertaken for the welfare of the women. These include creche centres, functional literacy for women, supporting the activities of the Mahila Mandal through small grants for organizing environmental sanitation drives, cleanliness drives, cultural programmes etc.

Cultural activities are supported by the Corporation both financially and by stimulating them to organize such activities. This include study tours, film show, seminars, social get togethers, exchange of text books, music and dance centres, coaching classes for weak students, purchase of community radios, leadership camps etc.

PROCESS OF CHANGE AND BASIS OF THE CHANGE PROCESS

The process of change in the slums has been based on the strategy of building up community-based organizations - the Basti Welfare Committees, the Mahila Mandals and Youth Organizations by the community organizers who always emphasize the representation of the poorest and the most disadvantaged section of the communi ty. They worked with these committees to enable the slum dwellers themselves to identify and prioritise their needs, assisted them to solve these problems on a self help basis, and, supplemented the resources of the Corporation to create the physical infra structure required or maintain the facility created. This philos ophy and practice is strongly evident in the activities

of the Municipal Corporation prior to the commencement of ODA assisted project HSIP Phase II and III. During the period 1967-83 and particularly up to 1980, most of the activities were carried out on a item by item basis of preparing the community to change themselves and then providing the financial, technical and liaison assistance of the UCD and Engineering Departments. This process suited the low resource position of the Corporation and also ensured that the maximum utilization was got for every penny spent by the Corporation on the slum improvement programmes. Between 1981-83 the Municipal Corporation made a concerted bid to systematically improve 200 slums for all the basic services. Together with UNICEF assistance, the Municipal Corporation spent more than 50% of the total Corporation expenditure, about 350 lakhs during this period, for environmental slum improvement of Hyderabad. By 1983 it was evident that there was a major environmental change in the 142 slums where the urban basic services were already provided wherein, excepting the shelter conditions (which required massive injection of funds), the environment could eaily match the middle income localities and were no longer the source of breeding diseases.

However, poor quality shelter was strongly recognised as one of the fundamental problems of the slums. At the same time it was recognised that, in the 313 slums where only sporadic slum improvement services had been provided, not much development could be made without substantial input of funds. Following this the Hyderabad Slum Improvement Project Phase II and III proposals were drawn up for time-bound and systematic coverage for all the basic services along with convergence of housing and government economic support programme into the slums through the project. These intensive activities have been planned so as to create a tangible change, as well as, to prevent cost overrun due to inflation and delay in execution. Thus during the HSIP Phase II and III the different components of the project enumerated in Section V vis economic support programmes, health, engineering and physical infrastructure, women and child welfare/cultural programmes, literacy programmes are being carried out by separate wings, more or less in isolation from the community organization activities which is the chief activity of the UCD department functionaries. During these phases, the previous ground work done by the UCD department in organizing the community and creating great initiative in the community is paying off, organizations are facilitating the various components of the project by their respective departments. Same degree of assistance and the participation is also evident in identification of the candidates for training as Balwadi teachers, community health volunteers, adult literacy teachers etc.

Rapid changes are taking place in the slums being covered under the HSIP Phase II and III in terms of infrastructure development, socio-economic improvement and environmental improvement. But in terms of extent of participation by the community in the multiple activities initiated on simultaneously in the slums, there has been a change in the attitude of the community from one of self help to one of dependency upon the Government and external agencies. Prior to 1983, the amenities and facilities created by the Corporation whether it was the community hall or public water posts or storm water drains, sewer lines, etc was at a pace which the community could keep up with. The community was prepared for these facilities and contributed in some way to the creation of these facilities, and therefore the community undertook to maintain most of the facilities to the extent possible. Under the HSIP Phase II and III, while a physical change is evident in the slums, the participation of the community which is a great necessity for maintenance of the facilities created has become difficult to elicit,

chiefly because these programmes have not been adequately community-based to prepare them for receiving and maintaining these inputs.

Thus, in the period prior to 1983, the major positive change that was evident in the slums was in terms of the attitudes of the slum dwellers with emphasis on awareness, self reliance and self help, as well as, environmental changes owing to the sporad ic services provided by the Corporation. On the other hand in the slums which have experienced the ODA intensive Phase II and III the physical change and improvement is markedly evident due to the simultaneous improvement activities of the HSIP project and convergence of the housing programme and socio-economic programmes. The involvement of the community in execution and maintenance of these facilities is markedly absent in most of these slums. Additionally, in these slums, an attitude of dependency and expectation from the government for providing facilities is evident. There is greater expectation that the government will maintain the amenities created in the slums. The change in the attitude is more evident in the response to loan recovery under the housing programme. Prior to 1983, repayments were made much more promptly and on the whole, the housing programme through loans could be rated a success during this period. Of late the recovery of loans given under the housing programme has been much more delayed, and in some cases, refusal to repay has been encountered. Owing to the lack of sufficient participation by the community (from the stage of planning the layout to building the houses), there is lack of involvement of all the Slum Associations and Community Organizers in recovery of the loans compared with the programmes initiated with the participation of the people.

On the other hand, the programmes which included the people's participation and those in which the Basti Development Committees and the COs are actively involved by the concerned department, have fared much better in terms of utilization by the community, participation in the maintenance and protection during times of crisis. For eg: the Balwadi scheme, Nutrition Centres, Vocational Training centres and economic support programmes were the focus of activities of the COs in collaboration with the local slum associations since 1965. These activities even in the HSIP Phase II and II are highly successful in terms of participation and maintenance by the community since the COs and other UCD functionaries are continuing to be strongly associated with these programmes. The self-help community halls and milk booths which were constructed prior to the start of the project are also well maintained and better utilized for large number of community activities, as compared with the rapidly completed constructions under the HSIP Phase II and III. During a major disturbance in the city, the community halls and milk booths constructed on a self help basis were fully preserved, whereas those constructed purely by the Department were burned to the ground in the affected areas by unruly mobs as these facilities were not protected by the community.

Again, this phenomenon is prominently seen in the case of the housing programme prior to 1977. Prior to 1976, the housing programme was functioning in isolation from the UCD activities under the slum clearance activity of the State Government wherein the slums were demolished and multistoreyed tenements were built by the Slum Clearance Board for the slum dwellers to reside. None of the original slum dwellers were residing in the 2368 apartments so built. However, on the other hand almost 10,000 houses have been constructed on a self-help basis since 1977 financed by loans from banks and the HUDCO and less than 1% of the slum dwellers had sold or rented out these tenements.

In the case of the health programme, it was started in 1983-84 with three teams in Phase II and expanded to 20 teams in the HSIP Phase III, 1988-89 onwards. These teams were charged with preventive health functions. However, owing to the functioning of these teams in isolation from the UCD grass root functionaries, not much headway has been made. The coverage of eligible groups for immunization was found to be more or less similar in the ODA intensive slums and the slums which were not yet covered under the HSIP project inspite of having a health programme. For example, the immunization coverage of children under one year was only 42% and it was similar in both the project slums as well as the slums not yet covered by the project even though immunization was the major thrust of the health programme.

Thus it can be seen that the major change has been based on the strategy of community organization, felt need identification and self help programme which was the focus of the UCD department. The success of community participation and therefore the long term success of all the multisectoral activities initiated under the HSIP Phase I,II and III has been more or less proportionate to the degree of involvement of the community organizers and Slum Associations in the respective programme.

Another basic strategy has been to channelise the funds of other agencies through the UCD department of the Corporation to ensure their proper utilization for integrated development of the slums. Thus the entire funds of the State Government SC,ST, Corporation and BC corporation as well as Government Economic Support Programme for the Weaker Sections of the Society was channelised through the UCD department. This has resulted in the planned developmental change in the environment and living standards in the slums.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

A. Organizational Structure in the UCD Department

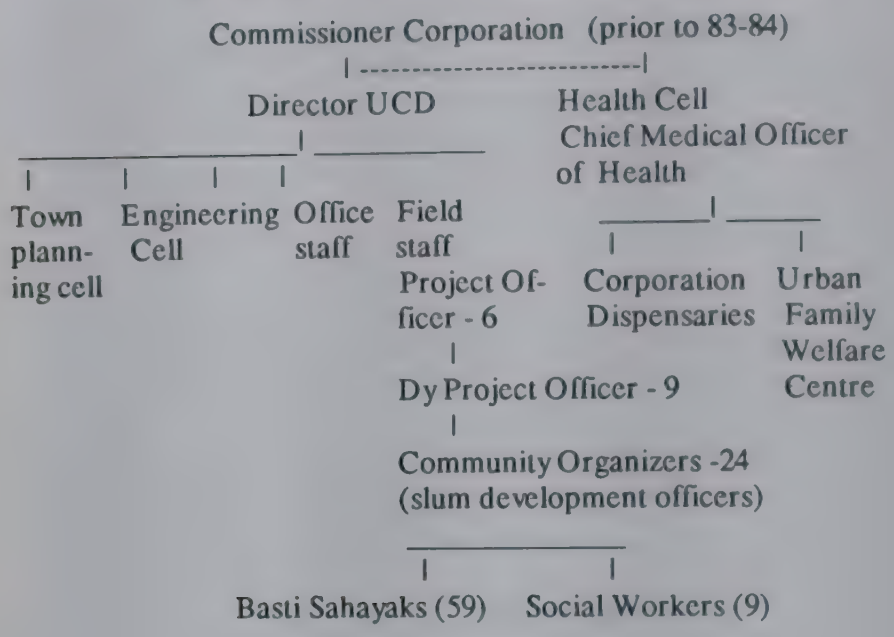
The Organizational structure has been changing through the different phases. Since 1967 upto 1980 the Organizational Structure of the UCD Department chiefly consisted of the core staff of Community organizers headed by the UCD Project Director (formerly termed the Project Officer). At the time of starting the UCD project in a slum population of about 12,000 in 1967, the Project staff consisted of the Project Officer Dr G Surya Rao and eight community organizers who were State government officers already working in various departments of the State Government in close contact with the public and with a reputation and experience of good community-based work. As required under the Government of India Planning Commission guidelines, 50% of the COs were female. The background of the COs ranged from Education Instructor to Superintendents of Children's Home Mukhya Sevikas and Extension Officers of Panchayat Samithis, etc. They were subsequently trained in social work for two months where their aptitude was tested. Subsequently the staff was expanded to a strength of thirty field functionaries headed by the Project Director. To this core staff was added the Engineering Cell and a town planning section to manage the increased scope of functions of the department.

Also 59 Basti Sahayaks and 9 social workers and 12 attender-cum-charimen were active as field staff. The Basti Sahayaks are paid on a regular scale but not

considered as Municipal Corporation employees. They provide overall motivation to the slum families and associations and assist them on a day to day basis in their efforts under guidance of the Department staff.

Thus all the concerned cells namely the engineering, town planning and community development sectors were under one line of command, the Project Director who had much experience in the field prior to placement in this post. There was more or less stable leadership of the Project Director with succession from the same Department. Briefly the structure could be summarised as follows.

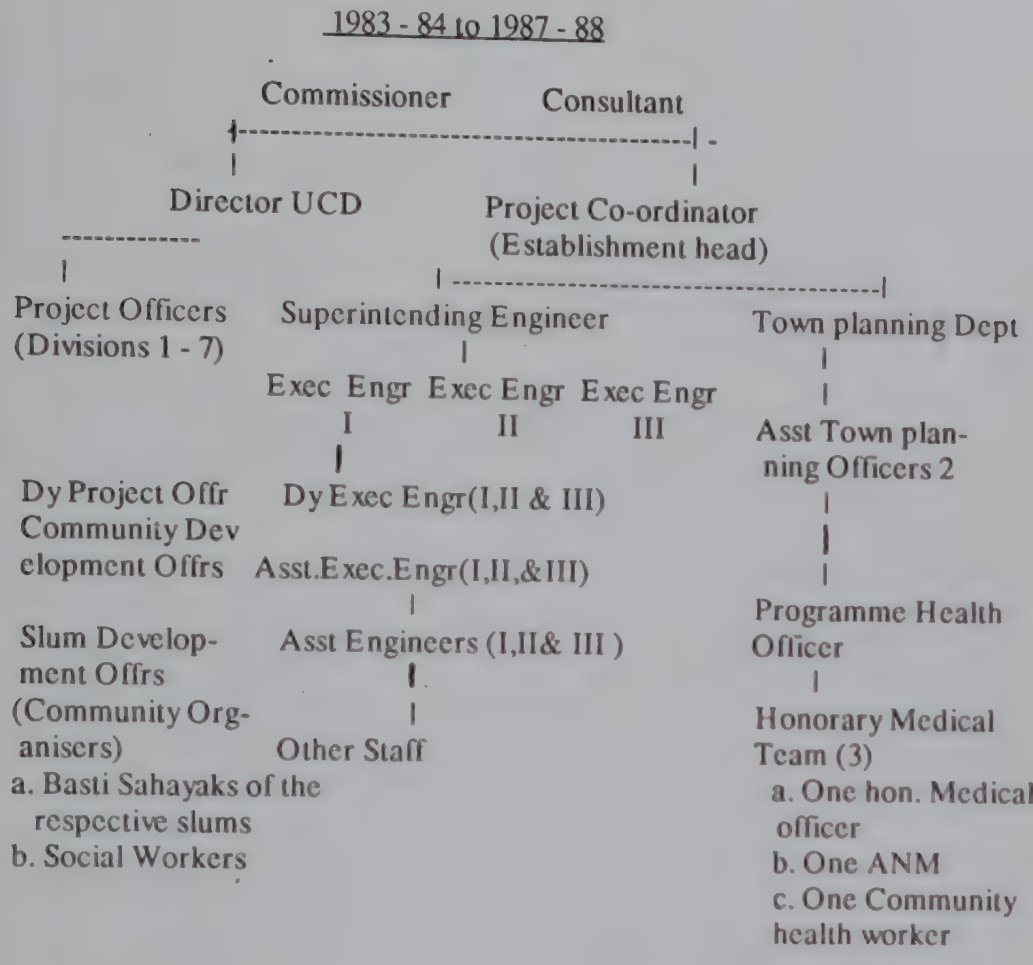
Organizational Structure of the UCD Department



B.Organizational Structure and Leadership under the HSIP Phase II and III :

With the commencement of the HSIP Phase II in 1983-84, it was envisaged to cover approximately 205 slums for all the inputs, and simultaneously incur an expenditure of approximately Rs. 11.24 Crores directly under the Project and an additional expenditure of Rs. 4.96 crores representing the Municipal Corporation share under the Housing Programme. This resulted in a massive expansion of the Project staff. The line of command was also redesigned. Under Phase II, the organizational structure was as follows :

Organizational Structure under HSIP Phase II

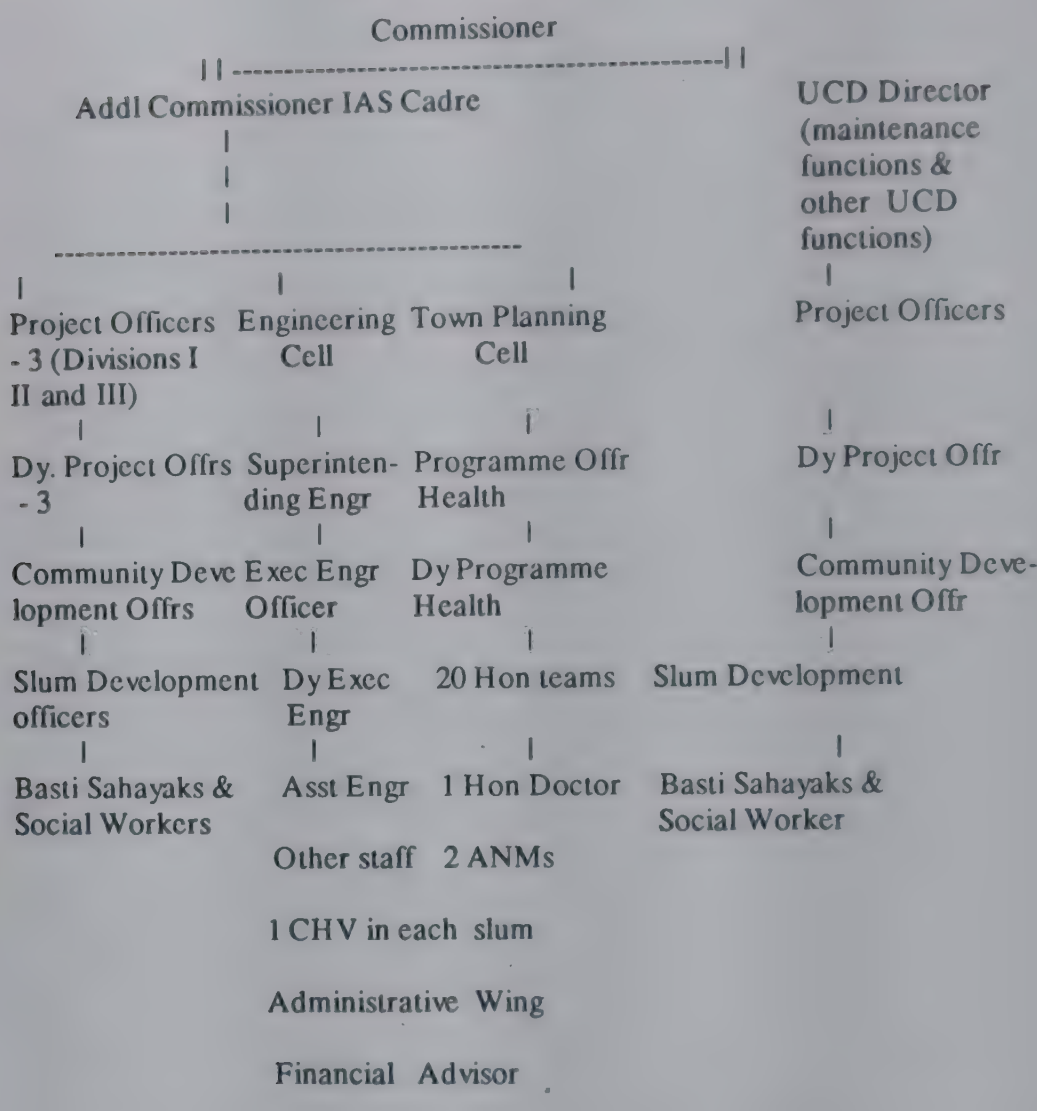


Thus during Phase II, the health component which was newly added, functioned directly under the control of Project Coordinator. Similarly also, the Engineering Wing which was greatly expanded was placed directly under his control. The Director UCD exercised administrative control over the UCD functionaries jointly with the Project Co-ordinator. There was no unified chain of command through the UCD director, and thus the health, engineering and socio-economic components functioned as separate departments.

In the HSIP III, the organizational structure has been further modified as follows. The UCD Director along with a few staff are expected to carry out the normal UCD functions of the Corporation and this wing has been bifurcated from the Project. The slums improved as per schedule year by year, are handed over to the UCD department for maintenance activity. The HSIP activity is being carried out under the leadership, of the Additional Commissioner (ODA) appointed from the IAS cadre, who administers and leads all the departments. The organizational structure is as follows :

Organizational Structure during HSIP Phase III

(1988-89 to 1991-92)



Owing to the disadvantages of the Departments working separately observed during Phase II, a change has been brought about under the HSIP - Phase III. All the components have been brought under the leadership of one single administrative head, the Additional Commissioner. Owing to this post being filled by a person from the Civil Services Cadre, the incumbents are liable to be transferred out frequently. Since then providing a stable leader at this level, which is critical, has been subject to the vagaries of transfers by the State level Administration.

C. Leadership

1. Leadership at the UCD Departments/Project Level

The tradition of a UCD leadership committed to community organization was established by the Project Officer Dr G Surya Rao ever since the UCD was established since 1967 (He was later designated as the UCD Director). This tradition of a stable committed leadership has continued through successive

UCD directors. Hence any programme introduced for slum development had been integrated with the community organization activity of the UCD department upto 1983.However, since the inception of the ODA assisted HSIP Phase II, with the need to expand the establishment as well as place it under the control of a higher level administrative officer, the leadership to the project, has been from the administrative cadre outside the UCD department. As a result the top leadership is frequently changed just as he starts getting involved and committed to the community development approach.

2.Leadership at the Community Level

At the community level, in the initial stages of activity the leadership is provided by the community organizers (the Slum Development Officers) who are engaged in creating awareness, identifying local leaders and developing local leadership especially among the disadvantaged sections of the slums including women. Subsequently the community work is taken over by the Basti Committee and other local organizations. Of late, since the commencement of the HSIP Phase III, neighbourhood committees are being attempted to be formed on the lines of the Visakhapatnam Slum Improvement Project with one member selected from every ten families living in consecutive houses or in a lane, to ensure a more broad based and fairer community based leadership.

COLLABORATION AND CONFLICTS WITH THE OTHER GOVERNMENTAL AGENCIES, THE VOLUNTARY AGENCIES AND THE COMMUNITY

A. Collaboration with other Agencies

The UCD department has wide ranging contacts and collaboration with several agencies in its efforts to develop the slums.

(i) Banks

The UCD department collaborates with the banks to provide loans for purchase of cycle rickshaws, sewing machines etc. A massive housing programme with Bank loan assistance was initiatedin 1977 and until 198d3 the Banks were providing loans at concessional interest rates with the persuasion of the UCD.

(ii) Housing and Urban Development Corporation (HUDCO)

The Municipal Corporation has an ongoing collaboration with the HUDCO to ensure standard housing for the slum dwellers. In fact since the ODA assisted Project began, the entire HUDCO scheme for Hyderabad is being channelised through the Project to ensure proper utilization. Under this scheme, the HUDCO provides a loan of Rs. 13,500 (formerly it was R. 6000/- upto 1983), the Corporation provides a subsidy of Rs.1000 and the beneficiary contribution is Rs.500/- or more to meet the remaining cost.

(iii) Supplementary Nutrition Programme of the State Government

The programme by the Health Department was a failure with the 230 centres closed down in 1980 due to the resistance of the parents to the R.T.E food being provided. The UCD department took over the project. With the help of community

education and study tours to he R.T.E factory, they were able to successfully restart 212 centres with good attendance.

(iv) The Scheduled Caste, Scheduled Tribe and Backward Class Corporations

These Corporations provide loans and subsidies to improve the income generation capacity of the economically and socially weaker sections of the society under the government Economic Support Programme. The SC, ST and BC Corporation of Hyderabad District Collectorate channelise all the inputs to the city through the UCD department only which ensures proper identification of the beneficiary, providing the right type of loan depending upon his skills, proper utilization to some extent, repayment of the loan.

(v) There is constant collaboration with the voluntary agencies such as Rotary, Lions and other organizations to financially assist extremely poor beneficiaries in the housing programme which requires beneficiary contribution), in organizing health and other check-ups, small grants for locally organized cultural events, books for the libraries etc. Six major community halls have been constructed by mobilizing funds through these sources.

B. Conflicts and Constraints, Problems Experienced in Implementation of the Project

1.The policy of the UCD functionaries has been to evolve the grass root organizations by a slow process involving the already powerful or influential leaders - political, religious or othewise without attacking their base. Pressure groups were tackled carefully with the guidance of the senior functionaries. Hence the conflicts with the community or its leaders has been minimal. Conflicts chiefly arose in the housing programme to decide the size and number of plots particularly in slums where certain families had occupied a relatively larger piece of land, which were overcome by constant pressure and motivation by the UCD Department.

2.Another major source of constraint in the housing programme was the lengthy judicial process to establish the Municipal Corporation as the legal owner of certain land, for which fictitious titles were fabricated by private individuals.

3.A third and greatest obstacle felt was the constant interference of political personalities such as MLAs, excouncillors or representatives of the area who, in order to expand their own base tried to adversely influence the processes of self help and participation. This was done through promising better benefits and creating factions in the slum communities, promising to get the housing and other loans waived on various grounds such as , beneficiary belonging to scheduled caste or tribe, etc. In fact in the case of SC, ST families who have availed the housing loan, the repayment has been poor due to such interference which creates a bad precedent for the other families too. However, the measures taken by the Basti Committees along with the substantial financial clout wielded by the UCD department gives the COs and local leaders sufficient influence to prevail upon the better sense of the people. In fact it was felt that during 1967 - 86 when there were no civic elections to the Hyderabad, Municipal corporation, the UCD process was well created and established. After 1986, when the civic elections were held and formal representatives came to power, the process has to some extent been diluted. About 20-25%^ of the Basti Committee members(

now being replaced by Neighbourhood Committees) are nominees of the local influential politician rather than of the people.

4.Another complication which had arisen lately regarding community based volunteers - health volunteers ad basti sahayaks who are being paid an honorarium have organized themselves into a Union demanding regular job appointment in the Corporation.

RESULTS

The developments in the slums have been taking place very gradually particularly in the area of community organization and participation.

1. Results in Terms of Achievements under the various programmes

A.Community Organization

As a result of the activities if the community organizers, since 1967 Basti Welfare Committees have been formed in almost each and every slum. Formation of local self-help organizations was at its peak during the phase of UNICEF assisted project activities : 1977 - 83.

By 1983, in addition to the Basti Welfare Committees, 135 youth organizations, almost 100 Mahila Mandals, five children's organizations and 21 Bhajan Mandals were active which were actively mobilizing and liaising the development activities in the slums of the twin cities. About 54 leadership camps were conducted towards developing leadership among them.

Since the commencement of the ODA assisted project, there has been a stress on formation of Neighbourhood Committees with the representation of each lane or each set of consecutive houses in the Slum Committee. In accordance with this, committees have been formed in 65 slums taken up during up during 1988-89 of which most are community based representatives and about 20-25% are nominee representatives of the local political leaders. this factor has come into play since 1986 when the first election to the civic body was conducted after 20 years.

B. Water and Environment Improvement

Under this programme, slum improvements had been carried out for the various services such as water, street lights, sewer lines, storm water drains, metal roads, community lavatory , etc on a sporadic basis upto 1980. During the period 1981-83, the Municipal Corporation implemented in part the HSIP Phase I under which each of the slums taken up, was brought up to the desired level of improvement by providing all the services before moving in to the next group of slums. Thus by 1983, 142 slums with a population of 1,22,000 were covered for all services and excepting systematic coverage for shelter improvement, the environment in these slums could easily match the surrounding middle class localities and were no longer the sources of breeding diseases. Between 1983-84 and 1988-89 (Phase II ODA assisted) an additional 210 slums for all these services with the added convergence of HUDCO funds for a systematic housing programme and the Economic Support Programme of the government.

During 1988-89 to 1991-92 (Phase III-ODA assisted) an additional 300 slums are being covered. By 1988-89, 65 slums were covered for these services under the HSIP Phase III. The details of achievements under the civic infrastructure during 1983-84 to 1988-89 are indicated in the table.

CIVIC INFRASTRUCTURE - 1983 - 1989

Sl.No	SECTOR	UNIT	TARGET	ACHIEVEMENT
1.	Roads	km	170-19	173-316
2.	S.S.Flooring	sq.mt	203425	225129
3.	Sewers	km	122-29	88-821
4.	S.F.Drain	km	49-49 .	33-319
5.	Community Lavatories	Nos	86	6 (5 x 6)
6.	Miscellaneous Works	Nos	57	147
7.	Community Halls	Nos	61	50
8.	Low cost sanitation works	Nos	19928	17124
9.	Street Lights	Nos	4426	4498
10.	Public water stand posts	Nos	665	574

Prior to 1983, the UCD department had already constructed 67 community halls on a self help basis and 8 major community halls with the collaboration of other voluntary agencies and donations. Several other facilities such as self-help milk booths were also constructed.

C. Economic Support and Income Generation Programmes

The details of results achieved under this programme are available upto 1983. These include the achievements during the UNICEF assisted period 1977-83 as well as work done before 1976.

(i) Skills Training

By 1983 about 98 sewing centres were established where about 3000 women were taught sewing and were subsequently selfemployed. Eight doll making centres were established where 190 women worked to supplement their family income, seven zigzag centres were established where 170 women were employed. Most of these were established at the community halls where the other activities such as Balwadis and others were also functioning.

About 881 persons were trained at shorthand/typing training centres set up. 610 beneficiaries were trained in motor car driving, 384 in auto rickshaw driving, 120 in radio mechanics and repairs, 99 in TV repairs, 123 in photography, 146 in computer punching/verification, 176 in airconditioning and refrigerator repair, 315 in fabric painting, 1763 persons trained in sewing machines repair, 75 in repair of electrical appliances, 19 in small savings mobilisation, 206 in rickshaw pulling, 135 in composing and printing. During 1983-89, 23 sewing centres were opened and about 696 women were trained.

(ii) Provision of Loans

Under the Economic Support Programme of the Government, loans were given to identified beneficiaries from the SC, ST and BC Corporation channelised through the UCD department. In addition bank loans were also given. About 1800 sewing machine loans, 305 cycle rickshaws loans, 3473 loans to petty vendors, were given for improving capacity of the slum families. These components were particularly strengthened in areas where housing programme took off so as to enable the families to achieve the repaying capacity to return the housing loans. In addition large number of petty loans for local needs such as purchase of iron boxes, masons tools, carpentry tools etc were given.

(iii) Formation of Co-operatives for Production and Marketing

Three garment making units were started where 70 persons got steady employment; one Lijjat papad unit was started where 155 women found steady employment; one Cardboard Unit was started where 30-80 persons were employed from time to time. In addition, Carpenters co-operatives were started to enable them to help themselves for various purposes.

C. Health Programme

The health programme has received systematic attention since the commencement of Phase III. Prior to this, sporadic activities were carried out in a few slums by visits of three health teams. Since 1988-89 twenty teams headed by an honorary doctor have been formed. There is a gradual improvement being seen in immunization coverage and family planning acceptance during the past two to three years.

D. Housing Programme

With the assistance of the Banks about 3000 houses were constructed after granting pattas to the slum dwellers. The cost of each house worked out to be Rs.6000 of which the loan component was Rs.4000. The repayments of loan and continued occupancy by the original allottees have been of a high order reaching almost 100% in some areas. Since 1981 the housing loans are being arranged through the HUDCO scheme. Under this scheme totally, 7188 housing units have been completed. Since these are self help housing schemes assisted by loans, without the involvement of contractors, almost 98-99% of the original allottees have remained in the houses constructed, as compared to the results of the Slum Clearance Programme implemented prior to 1976 wherein none of the original 2368 allottees were found to be resident in the multistoreyed tenements constructed.

E. Cultural Activities, Literacy/Education Programmes and Welfare Programmes

About 160 Balwadis were started prior to the HSIP Phase II and III and since 1983-84 under HSIP Phase II, 45 additional Balwadis have been started. Fifty anganwadis were started during 1982-83 under the ICDS scheme. Totally about 101 adult literacy centres were opened in every slum taken up is envisaged to be opened. Several other activities such as creches, self help libraries have been started in some slums. Since a few are closed down due to lack of continued support or target group, and new are opened in other slums, the number of these facilities which are active is difficult to ascertain.

Several cultural activities with the help of grants from UCD department have been organized particularly during the intensive community work done during the period 1977-83. About 13,000 persons were taken on study tours within and outside the state including a large number of slum dwellers who were taken to the R T E factory of Hyderabad to educate them on the ingredients and nutritious value of the RTE food being served under the Special Nutrition Programme to underfive children and pregnant mothers. Large number of educative and cultural film shows covering more than a lakh of people, social get-togethers, etc have been done.

2. Results in Terms of Socio, Economic and Health Status Changes

In terms of change in quality of life and capabilities of the people themselves, there has been a substantial change, which was quite marked before the Hyderabad Slum Improvement Project Phase II and III with massive inputs, was started. In all the slums where environment improvement schemes have been completed, the general environment is comparable to the neighbouring middle class localities. Particularly in the slums where housing programme has been completed, the entire appearance and outlook of the people have changed. Since the economic support and vocational training programmes, closely linked to each other were undertaken in a big way in these slums after a period of initial community development and preparatory work, the improvement of income, the socio-cultural implications of forming committees and actively working groups, the need to contribute their own labour and savings for construction of their houses, co-operative self help in exchanging skilled and semiskilled labour among themselves to bring down costs, has promoted a culture of thrift and family cohesiveness as well as a reduction in the social evils such as alcoholism, and other problems. Surveys conducted show that the average family income has increased from Rs.200/- per month during 1977 to about Rs.400/- within 3 years of taking up intensive activities in 24 slums where Bank financed housing programmes were initiated in 1977.

It is too early to assess the results of the health programme since it has been initiated in a systematic manner only since 1985-86, and on a fairly large scale since 1988-89. However, since the health wing activities were not coordinated with those of the community Development Wing, the acceptance and response of the community to the health programme has been below expectation.

FINANCIAL RESOURCES AND EXPENDITURE

The sources and scale of funds has changed over the years.

1. Early Phase of UCD activities 1967 - 1976

i. The UCD budget sanctioned in 1967 when the project was initiated for a slum population of approximately 12,000, was Rs. 47,800 per annum with a Central Government contribution of Rs.15,000 and the remaining from the State government. This does not include the cost of sporadic improvement works undertaken in the slum.

ii. By 1974 with the expansion of activities to three more wards of the City, covering a population of an additional 30,000 the budget was increased and the

Municipal Corporation and State government were sharing the costs equally between them.

iii. In 1976 the UNICEF started providing assistance and with this development this project gained momentum. By 1980 the direct expenditure on the UCD department activities was Rs. 30 lakhs of which UNICEF contributed Rs. 7.8 lakhs., the State Government contributed Rs. 7 lakhs and the remaining was spent from the Corporation funds.

On the slum improvement and engineering works (physical infrastructure) during the Fifth Five Year Plan 1975-1980, a sum of Rs. 373.37 lakhs had been spent. During this period 1980 - 85 (HSIP Phase I) an amount of Rs. 349 lakhs was spent to comprehensively improve 142 slums. Out of this the State Government contributed Rs. 116 lakhs, the UNICEF contributed approximately Rs. 24 lakhs and rest was borne by the Municipal Corporation. In the HSIP Phase II which was carried out with financial assistance from the ODA - UK, Rs. 1,557 lakhs was spent to develop 210 slums to the desirable standard. The convergence of funds of HUDCO was Rs. 766 lakhs. During Phase III, the proposal provides for an expenditure of Rs. 3534 lakhs to cover about 76,000 families in about 300 slums which works out to a percentile expenditure of Rs. 638. In addition the convergence of funds of the HUDCO under housing and shelter improvement programme, amounts, to 2700 lakhs. Thus the total investment in the project slums during phase III amounts to Rs. 6234 lakhs or approximately Rs.1120 per capita (or Rs.7840 per average household).

The costing of the programme components is given in the following tables:

A.Broad Programme Components and Related Costs (in lakhs)

Physical Infrastructure	:	2,333.200
Health Programme	:	75.548
Literacy and Education	:	72.140
Economic Support Programme	:	53.500
Establishment and Equipment	:	355.370
Training	:	31.520
Monitoring and Evaluation	:	12.000

		2,933.278 or say 2934
Plus inflation @ 20%		600.000
Total of "A"		3,534.000
		= = = = = = = = = =

B.Housing and Shelter Improvement (Through HUDCO Funding directly by convergence into the project:	Rs.2700 lakhs
Overall Cost A + B	Rs.6234 lakhs

A.4 Targets:

Table-2
Line Estimates for Civic Infrastructure under HSIP -III

Sl No	Amenity	Infrastructure Existing not requiring upgradation	Existing infrastructure rrequiring	Proposed new infrastructure upgradation	Total cost of (4+5) (in lakhs)
1	2	3	4	5	6
1	WBM/BT Roads (Sq.Mts)	1,14,474	1,63,758	3,72,558	313.953
2.	Sewer lines (rmt)	72,410	-	71,055	88.818
3	S W drains (rmt)	31,771	-	20,699	89.397
4.	S S Flooring (Sq.Mts.)	38,453	80,767	93,214	54.332
5	Inspection Chambers (Nos.)	3,122	-	27,950	139.751
6	Community Latrines (seats)	253	559	241	19.430
7	Community Halls (Nos.Sq.Mts)	1,269	2,616	6,107	88.105
8.	Septic tanks (Nos)	3	-	27	13.350
9	Low Cost Sanitation (Nos)	-	-	12,000	48.000
10.	Street Lights (Nos)	-	1,125	2,170	76.745
11.	Transformers (Nos)	-	-	68	68.00
12.	HMHW Public Stand Posts (Nos)	-	-	5,271	-
13.	HMHW Private pipe connections(Nos)	-	-	8,396	1,35.980
					1,135.861

or say Rs.1136 lakhs = = = = = = = = = =

Costing of Health Programme for HSIP Phase III
(Rupees in lakhs)

Year	No of Centres	Target Population	Honorarium	Drugs @Rs.3/- per head	Equip-ment	Furniture for medi-cal teams
1	2	3	4	5	6	7
1988-89	70	24,300	10.80	72,900	5.00	2.00
1989-90	150	59,940	10.80	1,79,820	-	-
1990-91	225	90,720	10.80	2,72,760	-	-
1991-92	300	1,23,120	10.80	3,69,360	-	-
Total			43.20	8,94,840	5.00	2.00

Year	vehicles for Medical Team		Stationery	Training	Innovat-ive Prog-ramme	Total
	8		9	10	11	12
1988-89	4.00	50,000	3.33	1.25	27,60,900	
1989-90	-	50,000	0.72	1.25	15,06,820	
1990-91	-	50,000	0.675	1.25	15,95,260	
1991-92	-	50,000	0.675	1.25	16,91,860	
Total	4.00	2,00,000	5.400	5.00	75,54,840	

FACTORS AFFECTING THE SUCCESS OF THE PROJECT

A.OrganizationalFactors

(i)The success of a programme of health/community development implemented with community participation through the government sector has been largely due to the initial core team of UCD Staff of Dr G Surya Rao and six community organizers, who were hand picked for Community Development work and the commitment of the Municipal Corporation to maintain community participation as a vital component of any programme initiated under the UCD Department. Following the establishment of this tradition in the beginning of the UCD activities, the commitment could be crystalised in the form of an organizational structure oriented to community organization and development. This structure which is rather unique for Municipal Corporations (and other government departments), consists of the concept of community organizers and later on the Project Officers and social workers who form the core staff of the Department. The procedure of preceding developmental activities with community organization into Basti Committees by these staff was firmly established during the early phase 1967-1976 which was consolidated during the UNICEF assisted project period, 1976-81. Subsequently when the Hyderabad Slum Improvement Project at first

with UNICEF assistance and later with ODA assistance was started, the same tradition and procedure continued.

ii)The sustained track record of fostering community participation in the government programmes both under UNICEF and ODA, assistance, can also be attributed to maintenance of good leadership in the project, although the persons occupying the posts of Commissioner were changed. Through all these changes, leadership inputs to the project and commitment to slum development have remained of a high order at the top level of administration of the Corporation.

iii)One of the most important factors has been the unchanging stable staff maintained in the UCD. The staff strength has been expanded but most of the original staff appointed in 1967 and trained painstakingly have been retained without transfers. In fact the leadership of the UCD is provided by a Project Director, who, except the first incumbent Dr G Surya Rao, has been appointed to the post by promotion. There is a strong commitment to thorough training of the newer staff in-service, by the existing field staff, which has remained in a strong commitment of the staff to urban community development work.

iv) Another major factor for the remarkable change brought about in the slums has been the active collaboration solicited and nurtured by the UCD Department with various agencies - governmental and non-governmental, resulting in much greater agencies than each agency could have achieved in isolation. The collaboration between the Project, housing agencies, banks, District Industrial Centre, etc., resulted in mobilization of community participation for all programmes.

v) An important aspect which has resulted in a harmonious convergence of large number of civic services has been the strategy of bringing together the community organization staff, engineering and town planning sections under one administrative head, the UCD Project Director.

The advantage of this strategy seen when one observes that, under the HSIP-Phase II when all these departments as also the health department worked independently each other, the success of the programme and of community participation, timely coordination of the various services, and other aspects, were not as favourable as before, even though the community had been well prepared prior to Phase II. Again the case of health programme bears mention. Even though the health programme was launched in 1985-86, the health functionaries felt that much more impact could be made by linking up health and family welfare along with the socioeconomic and housing programmes through the UCD functionaries.

B.Financial Input Factors

A very important feature which, the project officers also feel, has influenced the degree of community participation, is the substantial financial inputs and expenditure which have been incurred by the government in the Project area. Particularly under the ODA assisted project area towards tangible benefits and assistance like housing and other inputs has been quite substantial, approximately Rs.8,000/- per household on an average.

C.Strategy Factors

i) The strategy of slowly catalysing community based organizations the Basti Welfare Organizations and involving them in all activities and inputs provided by the Corporation in the slum areas resulted in consolidation of these Committees and solid presence of these Committees has been established.

ii) The initial strategy of providing partial support only to communitybased programmes such as balwadis, sewing classes, etc. , which were started on felt need and self-help basis, made these

programmes highly successful and on-going even after the community organizers had stopped intensive work in those slums.

CONSTRAINTS EXPERIENCED BY THE PROJECT MANAGEMENT AND GAPS IN PROGRAMME IMPLEMENTATION

i)Lack of Stable Leadership during the HSIP Phase II & III

A major constraint has been the frequent change of the leadership of the HSIP particularly after it was delinked from the UCD department since 1983-84. On the one hand, the HSIP has assumed complex proportions owing to the size of the budget, size of the city and slum population (8 lakh slum population), and diverse nature of services sought to be provided, which required substantial time for the administrative head to become familiar with and become committed to the community approach. By the time the leader incharge of the projects gets involved, he is replaced in the course of the vagaries of transfers. This has resulted in a dimunition of commitment to the community development approach, down the line, with the result, that the Project has of late become more target oriented and consequent lack of adequate community participation.

ii) While a good and viable infrastructure has been created in the form of community staff and honorary doctors, who do not place much demand on the corporation resources in terms of recurring expenditure (salaries and other staff over-heads), the content of the primary health care programme needs greater attention, now that the health system for the slums has been set up. It is known that there is a high prevalence of malaria, filariasis, diarrhoeal diseases, and other communicable diseases. For control of these diseases well-established principles, mechanisms and manuals for implementation of control programmes are in operation in the rural areas. Considering the high degree of community awareness and community development infrastructure that has already been built up, orientation of the health staff to implement these programmes could result in better utilization of the health system for primary health care and disease control.

iii) There is need for an inbuilt system of collaboration between the health wing and the community organization wing. A major constraint faced by the health teams is that, since they operate in isolation, they are not well accepted and there is not enough participation in the health and family welfare programes. The health functionaries, felt that the community organizers should be enabledm, by suitable administrative adjustments, to facilitate the health and family welfare programme, owing to the credibility and rapport they already enjoy with people.

iv) There is a serious question with regard to the post-project sustenance of the assets, facilities and activities created at a very rapid pace under the project. Since the work has been carried out chiefly with emphasis on achievement of the physical targets (owing to the time factor) the community has not been prepared or conditioned to treat these facilities and assets as their own which they would have to assist in maintenance in future. While the Municipal Corporations are able to collect taxes in other localities better income towards maintenance, whether they would be able to successfully do so in these developed slums is a major question. Failing this, the local organizations would have to be activated to take over the task of mobilizing the resources locally for these activities.

ANNEXURE I

JOB CHART OF COMMUNITY ORGANIZER

He is a Gazetted Officer in the Project working under the supervision and control of Project Officers and Deputy Project Officers.

1. To identify slum areas

2. To establish contacts with families and local voluntary organizations

3. To identify local leadership and develop patterns of working with them

4. To assess local needs, local resources and priorities while working with local people and the Voluntary Organizations

5. To motivate and form welfare associations where not existing

6. To create awareness and urge for better living in the people through motivations,demonstrations and conducted visits and use of audiovisual aids

7. To plan activities suitable to the area based on expressed felt needs with full involvement of beneficiary groups and local organizations and ensure local participation

8. To develop local initiative and to organize activities based on selfhelp and mutual aid

9. To strengthen local voluntary organizations through supporting programmes and develop local leadership(Youth) by arranging programmes and training courses,etc.

10. Coordinate between the local organizations and the Municipal Departments at Circle level

11. To coordinate between the local organizations and outside agencies including Government Departments and service organizations and financial and technical institutions

12. To bringout mutual understanding and better cooperation in matters of common interest on neighbourhood basis

13. To ensure fuller utilization of technical and welfare services available for improving the living conditions of the people

14. To work for improving the environmental conditions in the area especially in slum areas

15. To provide house site pattas and housing to the slum dwellers

16. To plan and organize programmes towards socioeconomic development of poeple

17. To improve health and nutritional status of slum dwellers through integrated health care programmes including immunization and antenatal care.

18. To mobilize youth and channelize their energies towards building up a healthy neighbourhood.

19. To develop hobbies, skills and talents among the youth (men and women) through vocational training programmes to enable gainful utilization of leisure time and earn supplemental income .

20. To bring about change in the outlook and attitudes of people towards a better life

21. To conduct socioeconomic survey of slums family and slum profiles through Basti Sahyaks and Social Workers

22. To assign field work including motivation work to Basti Sahayakas and Social Workers and guide and supervise their work and exercise control over them.

23. To assist voluntary organizations in organizing local welfare programmes and arrange to provide monetory/technical assistance to the extent necessary.

24. To assist and guide the programme staff (Voluntary teachers) in carrying out the activity successfully, by way of providing necessary equipment, syllabus,centre classes,training programmes, maintenance of records and registers,etc.

25. To study impact of the programmes implemented by way of periodical reviews, get togethers with voluntary organizations,evaluation reports, interviews,etc. and evolve suitable methods and procedures to meet the requirements in consultation with the Project Officer/Director,Urban Community Development.

26. To ensure proper reporting and documentation at Project level by maintaining full details of the activities with beneficiaries, expenditure (UCD grants,beneficiary contribution,donations/aid from outside) and photographs,etc.

27. To ensure team work both at Office and field level on the basis of assigining responsibilities to the field staff.

Case Study: XIX

VISAKHAPATNAM SLUM IMPROVEMENT PROJECT -- URBAN COMMUNITY DEVELOPENT DEPARTMENT, MUNICIPAL CORPORATION, VISAKHAPATNAM

This case study of the Visakhapatnam Slum Improvement Project (VSIP) of the Municipal Corporation, with similar beginnings as the Hyderabad Slum Improvement Project is unique in many ways. With the Hyderabad Project, it shares the distinction of being one of the few Government Projects which aim to make the government programmes really the people's programmes, through an innovative organizational structure and innovative strategies integrating the socioeconomic, housing and other infrastructure- related programmes. The Urban Community Development Department which is in charge of the VSIP, has several other unique distinctions.

From the time of creation of the UCD Department in 1979 when the Municipal Corporation was formed, its objectives have evolved far beyond the usual course in government organizations given the usual cumbersome procedures, bureaucracy and red tapism. The UCD objectives have evolved from the primary objective (as defined by the Third Five Year Plan), of educating the community to accept the services, to the wider objective of becoming an agent of human resource development of the slum community to enable them to participate in the developmental process. Another distinction has been the successful integration of health, engineering, and socioeconomic development programmes and sucessful management of the programme staff under one administrative head who is himself actively involved in the field implementation of all the programmes, in addition to his administrative duties. This methodology of integrated implementation of health, socioeconomic housing and engineering programmes, has resulted in the community perceiving the Municipal Corporation as responding to their full needs, and not as individual Department of health contacting them to fulfill the targets and requirement of each individual programme. Another unique feature is the wide range of collaboration with voluntary agencies, medical college, private practitioners, banks, other government departments, housing corporation, etc. to converge all their services in a meaningful and cost-effective way.

The following gives a detailed account of the innovative nature of the Visakhapatnam Slum Improvement Project initiated in 1987, by the Urban Community Development Department of the Municipal Corporation with the financial assistance of the Overseas Development Administration (UK). The activities, and results bring out the leadership and organizational factors which have resulted in massive participation of the slum community in this multisectoral project. The innovative type of organizational structure, the strategy of nurturing community organizations and other strategies used are described.

BACKGROUND

The community served by the Urban Community Development Department - ODA-assisted Visakhapatnam Slum Improvement Project consists of a population of 1.91 lakhs (26% of the total population of Visakhapatnam city), residing in 170 identified slums of the city. The overall density of population is 375/acre and 70% of houses were Kutcha with thatched roof. These urban slums, like slums of any other city, had poor civic amenities, high degree of alcoholism, crime, ill-health and other problems connected with poverty, insecurity and unemployment. At the time of starting the ODA-assisted Visakhapatnam Urban Improvement Project, these slums had already experienced the intervention of the Urban Community Development Department of the Municipal Corporation over a period of ten years since 1979, when the town population exceeded one lakh,and the Municipal Corporation was created along with the UCD Department. The UCD department was created on the lines of a similar department in the Hyderabad Municipal Corporation. This department was purely entrusted with the responsibility of providing basic amenities to the slums, such as street lighting, electricity, open drainage, approach roads, and water supply, with a built-in mechanism of enlisting the cooperation and participation of the community served to ensure maximum benefit and utilization of the programme even by the most vulnerable section of the society . The chief thrust of UCD department was to create community organizations and a cadre of informed and active community volunteers, who would ensure the best utilization of resources as well as community maintenance of the facilities created. During the early years of its formation, the Department was headed by two officers deputed from the Hyderabad UCD Department, Mr and Mrs D G Rama Rao who had a rich experience of about eleven years of similar work in the slums of Hyderabad. With no other staff and very little funds for slum improvement activities they started working among the slums. Nevertheless they were able to establish links with the community and create a cadre of volunteers in most of the recognised slums. These slum volunteers worked with the community to facilitate laying of approach roads, maintenance of public water standposts, laying of drains, community cooperation to form proper layouts for the housing programmes of the Housing and Urban Development Corportion (HUDCO) for the economically weaker sections of the community , etc.

Encouraged by the experience of community involvement, the UNICEF came forward in 1982 to finance a comprehensive mother and child health programme to be implemented with the full participation of the community. For this Project, staff, chiefly of Community Organisers and social workers were appointed, whose major function was to stimulate and nurture the formation of Neighbourhood Committee consisting entirely of women, who along with their children were to be the target of the supplementary nutrition and income generation schemes under the project. The Neighbourhood Committee members were to be developed as mother leaders for the community, self reliante in mother and child health care in the slum community. Guided by the COs and social workers, these Neighbourhood Committees of mother volunteers had almost uniform representation of every lane in the slum, since one member had to be selected for every ten consecutive houses. These Neighbourhood Committees, working from 1982-86 under the Maternal and Child Health Project of the UNICEF, assisted and guided by the UCD functionaries, had achieved substantial changes in mother and child health status, particularly in terms of immunization coverage, nutrition awareness, intake of nutritious foods particularly proteins, some improvement in income of mothers under the supplementary income

generation scheme,etc. A major change was in terms of rehabilitation of disabled children and its prevention through immunization under the Childhood Disability of Management Programme which was responsible for creating considerable awareness, and also served as a motivation to hold the mothers on the Committees together and to work for this cause. These activities had been carefully nurtured by the UCD functionaries against a background of great poverty, alcoholism amongst men folk, insecurity and unemployment. As a result of these activities and sporadic slum improvement activities by the UCD department, a few slums were already developed to some extent when the Visakhapatnam Slum Improvement Project with ODA assistance was initiated in 1987.

The "Base Line" survey in 1987 showed that overall morbidity from disorders other than nutritionl disorders was very high, about 46%. This was not surprising in view of poor environmental sanitation,inadequate water supply and extremely poor housing in the slums. Caloric undernutrition was prevalent to the extent of 20% below the recommended norm of 2400 calories per capita. Deficiency of Vitamin A, B and C was highly prevalent. Surprisingly, awareness of need for protein was high ; protein, iron and calcium intake were more than 20% above the norm. Immunization coverage was found to be almost 75% among under-fives and about 56% among pregnant mothers. Infant mortality in these slums was of the order of 100/1000 live births, which was much lower than the usual figure of 160-230 in slums of other cities like Bombay and Calcutta. These findings confirm the extensive impact of the UNICEF assisted MCH programme. At the same time, these findings also confirmed the opinion of the UCD department leaders, that not much headway in health improvement can be achieved by a pure mother and child health programme however successful, unless the overall environmental, and housing conditions were improved, as well as, unless the men folk were also involved.

As in most slums, the majority of the population was employed as petty labour or petty vending business. Literacy rate was 21% as compared with an overall literacy rate of 58% in the city.

THE PROJECT: PHILOSOPHY AND OBJECTIVES

Against this background, the Municipal administrators drew up a massive, integrated slum improvement project proposal to develop the infrastructure health and socioeconomic status through community participation by capitalizing on the well- entrenched community organizations already created, and the established tradition of voluntary community activity in the slums. Similar environment improvement schemes had succeeded very well in the slums of Hyderabad where the community had been extensively involved. The Overseas Development Administration of United Kingdom undertook to fund the project and thus the VSIP was initiated in 1987 with following objectives:

1. To convert a significant proportion of the squatter settlements into environmentally acceptable shelters, by regularising the land tenure, and infrastructural improvements by providing basic minimum civic amenities viz. dust proof roads, internal roads and pavements, storm-water and sullage drains, street lighting, safe and potable water. These were to be achieved with an integrated, multi-dimensional and multidisciplinary approach.

2. To improve the health conditions of the slum dwellers by improving the sanitation by providing a package of integrated health services covering, Universal Immunization, Supplementary Nutrition, health education to reduce the childhood mortality and morbidity through extension of primary health care with strengthening the maternity and child care services.

3. To promote the literacy programmes and increase community awareness to solve the problems of the community with initiative, organization, self-help and mutual aid.

4. To develop community participation and cohesiveness in sustaining the infrastructure created .

5. To converge all the services as far as possible rendered by the different government and non-government organizations.

NATURE OF PROJECT AND ACTIVITIES

The Project has three main components:

i) The Engineering Component

ii) The Health Component

iii) Socioeconomic Development

These three components were planned to be channelised to the people with the participation of the community based on Neighbourhood Committees. The Project staff of community organisers and social workers were to act as a liaison between the people, who were to get the benefit of the programmes and the Municipal Corporation , HUDCO, other government and voluntary agencies whose funds and services were to be converged to the project area in an integrated manner through the UCD Department. The sound community-based organizations were to be responsible for maintenance of the civic amenities created under the project, minor repairs and replacements, and ensuring loan repayments by beneficiaries, and other liaison activities even after the project was terminated.

Thus essentially the Project aims at creating health and civic infrastructure housing, as well as initiating socioeconomic development programmes, and at the same time, create the community organizations to take over responsibility for subsequent maintenance of the infrastructure and further development. The activities include the following:

A. Community Organization

Eleven community organisers and 21 social workers are active to form the Neighbourhood Committees, one in each slum. After working with the community for some time, one member (male or female) from every ten consecutive houses, is selected who is acceptable to the community. The COs organize small group meetings with the help of local leaders, organise filmshows, street plays and folk songs to educate the community and arouse their initiative to form the Committees. Then they assist the Committees during the early phase, to organise meetings of the slum dwellers, where the COs explain the programmes proposed to be taken up, or explain the use of attending health education

meetings, the Mother leader Training Programmes, etc. The COs organised the various training programmes whether health, vocational training, or any other , make the arrangements for the teaching (District Industries Centre, the Andhra Medical College, Food and Nutrition Centre, etc.) and teaching materials. The Neighbourhood Committees are responsible to mobilize maximum number of the right target group to attend the programme.

Similarly all contact meetings between the community and the officials, for example, the housing programme matching grant schemes under which the community ha to raise certain proportion of the funds, health education meetings, are organised by the community organizers who act as the liaison between the community and the Municipal Corporation.

B. Health

The health activities are conducted under the supervision of the Deputy Project Officer.

1. *Health Care Services:* Primary Health Care Centres have been started at the rate of one centre for every five to ten thousand population, located at the Community Hall (which is also constructed under the Project) or in a rented building in the slum. Each PHC Centre is headed by an honorary doctor, who is a private medical practitioner of the area, who attends at the Centre on a part-time basis between 3:00 to 5:00 PM. They are paid an honorarium of Rs.1000/-per month. The doctor is assisted by one Community Health Volunteer.The CHV is a person from the slum selected by the Committee and trained at the Andhra Medical College for a month, followed by a months on-the-job training at an established slum PHC Centre of the city.

The CHV is trained predominantly in MCH activities and primary health care. She is responsible for collection and maintenance of vital event data, updating the same, maintenance of simple socio-economic and health data of families in family folders, identification of common ailments and referral to PHC centre, registration of eligible persons for antenatal care; motivating mothers for immunization of children;motivation for periodic check-up of the children, antenatal care, availing delivery services through trained dais; identification of dais practicing in the area to be trained at the School of Nursing and

Health Visitiors Training School; identification of suitable mothers to be trained in Mother Leaders Training Programmes; mobilizing the community to attend the Nutrition training programmes, etc.

The CHV is responsible for about 350-500 households in one, two or three slums and visits every household atleast once a month. During the morning she makes the home visits and in the afternoon she assists the doctor to conduct the clinic, prepare the monthly reports, etc.

At the clinic the doctor provides curative services, antenatal care, immunization services and emergency home visits. He also provides training and guidance to the CHVs, takes classes at the Mother Leader Training Programme and Nutrition Training Programmes. He is responsible for two PHC Centres and spends alternate days of the week at each of the clinics.

2 *Balwadis:* For the care and supplementary nutrition of underfives and pregnant mothers, preschool education and promoting the concept of MCH for

child survival, Balwadis have been opened in areas where ICDS Centres are not functioning. The Balwadi is housed in a rented building or at the Community Hall if available. Balwadis have been functioning in most of the slums, even during the UNICEF assisted phase 1982-87.

3. *Dais Training Programme:* Dais practicing in the area are systematically identified through the Neighbourhood Committee and CHVs and motivated for training for one month at the Community labour room. The training is provided by the Nursing College Students who are posted there on rotation . Dais are paid a stipend of Rs.300/- during their training. Identification and training of Dais was mostly complete under the UNICEF assisted Project. Under the VSIP it has been taken up as a mopping up operation to train anybody untrained so far.

4. *Universal Programme of Immunization* All eligible children are enumerated and covered for immunization with the help of 32 immunization teams formed under the leadership of the Andhra Medical College P and SM Department. Each team consisting of doctors and paramedical staff mobilized from the Andhra Medical College, the Municipal Corporaion, the Visakhapatnam General Hospital, HFWTC, ICDS, and the DIrectorate of Health Services. Since 1989, the UIP approach has been changed to that of the fixed centre approach wherein the CHVs and Mother Leaders in the community are expected to ensure that eligible children are immunized at the PHC Centres.

5. *Community Labour Room Facility:* For the benefit of slums located on the outskirts of the city, where the mothers are not able to avail, or are not aware of the facilities for delivery at the maternity homes and government hospitals in the city, the Corporation has constructed Community Labour Rooms with certain minimal equipment to conduct delivery. Trained dais of the area are made aware of this facility, so that they can conduct deliveries at this place rather than in the unhygienic conditions at homes. The community labour rooms are also manned for part of the time by students and staff of the College of Nursing, who also provide voluntary call services in case the trained Dais experience difficulty in conducting a home delivery.

6. *Mother Leaders Training Programmes:* Training programmes for one day each are organised, by which all mothers of the slum are expected to be covered in a phased manner. Twenty to thirty women at a time are mobilized for this programme, during which, they are taught about antenatal and post natal care, child care, nutrition of children and pregnant women, immunization, growth monitoring and family planning methods.

7. *Food and Nutrition Training Programme:* About once a month, the CHVs with the help of the community organizers of the Corporation and Neighbourhood Committee Members mobilize about 30 women for a Food and Nutrition Training Programme. The mothers are trained for a period of five days in proper food habits and cooking habits, mother and child nutrition, and general nutrition of the family.

8. *Clean Hut Competitions :* To drive home the need for cleanliness and hygienic *surroundings, during festival days and all special occassions, Clean Hut Competitions are organised to encourage them to keep the surroundings clean. Prizes are distributed in the form of stainless steel vessels to mothers who keep their huts and surroundings clean.*

9.Childhood Disabilities Management Programme: While some voluntary agencies are already active in this area, and the work was already initiated under the UNICEF Project, the systematic coverage and organization for health activities created under the ODA project, is being used to identify all disabled children in a systematic survey, with the help of CHVs. Special camps are organised to treat polio-affected and other handicapped children-deaf, blind and mentally retarded; folow-up action is taken to provide them with calipers and other aids. The orthopaedic specialist of the Andhra Medical COllege assists in the rehabilitation.

10. *Engineering Components:* Under the Engineering component, the following activities are carried out: construction of buildings for community halls and balwadis; construction of concrete pucca approach roads in the slums; concrete-lined open drains; public latrines and baths; street lighting; borewells, provision of dustbins; wherever the slums have come up abutting the major city drains, a retaining wall is constructed to the main drain to prevent overflow and flooding of the slums with sewage during monsoon season. A hydraulic excavator has been procured to desilt the major drains before the monsoon season, to prevent inundation with the sewage in the rainy season. Under the engineering component it is envisaged that totally about Rs.16 crores would be spent.

11. *Socioeconomic Programmes:*

i) In addition to environment improvement as provided for under

the Engineering Component, a major aspect of the Project is to mobilize the community to participate in the HUDCO's housing programme in a meaningful way. Social structures created in the form of Neighbourhood Committees are responsible to ensure that subsidized housing scheme by HUDCO, takes shape for the right beneficiaries. Under the scheme, the project has been able to catalyse the construction of about 5000 houses per year in the slums. For each house, in addition to HUDCO loan, a part subsidy is given by the state government. The open areas and free spaces available are being utilised for taking up social forestery, and development of plantations. Particularly on the banks of major drains, to prevent further encroachment on these unhygienic areas, plantations have been developed with community involvement.

ii)Use of the Community Hall: The community halls under the project are envisaged to become the hub of social and developmental activities in the slum. The Neighbourhood Committees meet here. In areas where no balwadi building is available, the balwadis are run at this place. Adult education programme, whether run by the Social Welfare or Education Department of the government, or the voluntary agencies active in the area is carried out in the community hall. At the community halls, equipment for conducting vocational training, like sewing machines, weldingunit or television repair equipment, are stored along with the blackboard and other such minor facilities. At each vocational training programme the (duration of which varies), about 10-20 students are selected from the local slums, and given training by the personnel of the District Industries Centre, to acquire skills of livelihood and self employment.

A community television set is purchased in every community hall with about two-thirds of the cost being first raised by the Neighbourhood Committee members from the people, and a subsidy of one third of the cost being provided

by the Corporation under the Project. The community television set is under the custody of the Neighbourhood Committee. Similarly a radio, small toys for children, etc. are purchased and stored here.

iii) Income Generation Programmes: The various financial agencies like nationalised banks and other agencies, are guided by the Corporation functionaries and the Neighbourhood Committees to identify suitable persons for the loans. For selection, a Committee is formed of one project officer of the UCD departmdent, one representative from the Scheduled Caste Corporation, one from the Backward Community Corporation, the banker, and other relevant persons. They are assisted in having an unbiased selection by the Neighbourhood Committee members and the local community organizers. Loans are given in kind and not in cash as far as possible. The loan is related to the vocational training programme a person has undergone, so that he can utilize the equipment for his livelihood.

iv) The Seed capital of Rs.3,000/- given as a grant by the ODA project for every Neighbourhood Committee, serves as a source from which petty loans (to the tune of about Rs.300/-) are provided to improve petty business, food vending, vegetable vending etc. The loans were expected to be repaid to the Neighbourhood Committee so that this capital could serve as a Revolving Fund which would then be recycled to other beneficiaries. However, while the loan amount given was properly utilized for economic improvement, repayment has been poor so that, this scheme has come to a standstill after initial disbursement of the seed money.

All these activities are being implemented in a phased manner. During the first phase 1988-89, 45 slums which were extremely backward and least developed were implemented for these activities. During this phase, the COs were very active in these slums to form and establish the Neighbourhood Committee. As the other programmes are being implemented, the COs perform a liaison function and develop the community organizations. Towards the end of this phase, they moved on to phase II slums (60 slums) which were implemented during 1989-90, for intensive community organization activities, and provide supervisory guidance to the Phase I slums. During Phase III 1990-91, the remaining 65 slums are to be implemented and during this period,the COs as well as other implementing agencies would be active in these slums, providing supervision and guidance to phase II and III slums.

ORGANIZATIONAL STRUCTURE AND LEADERSHIP

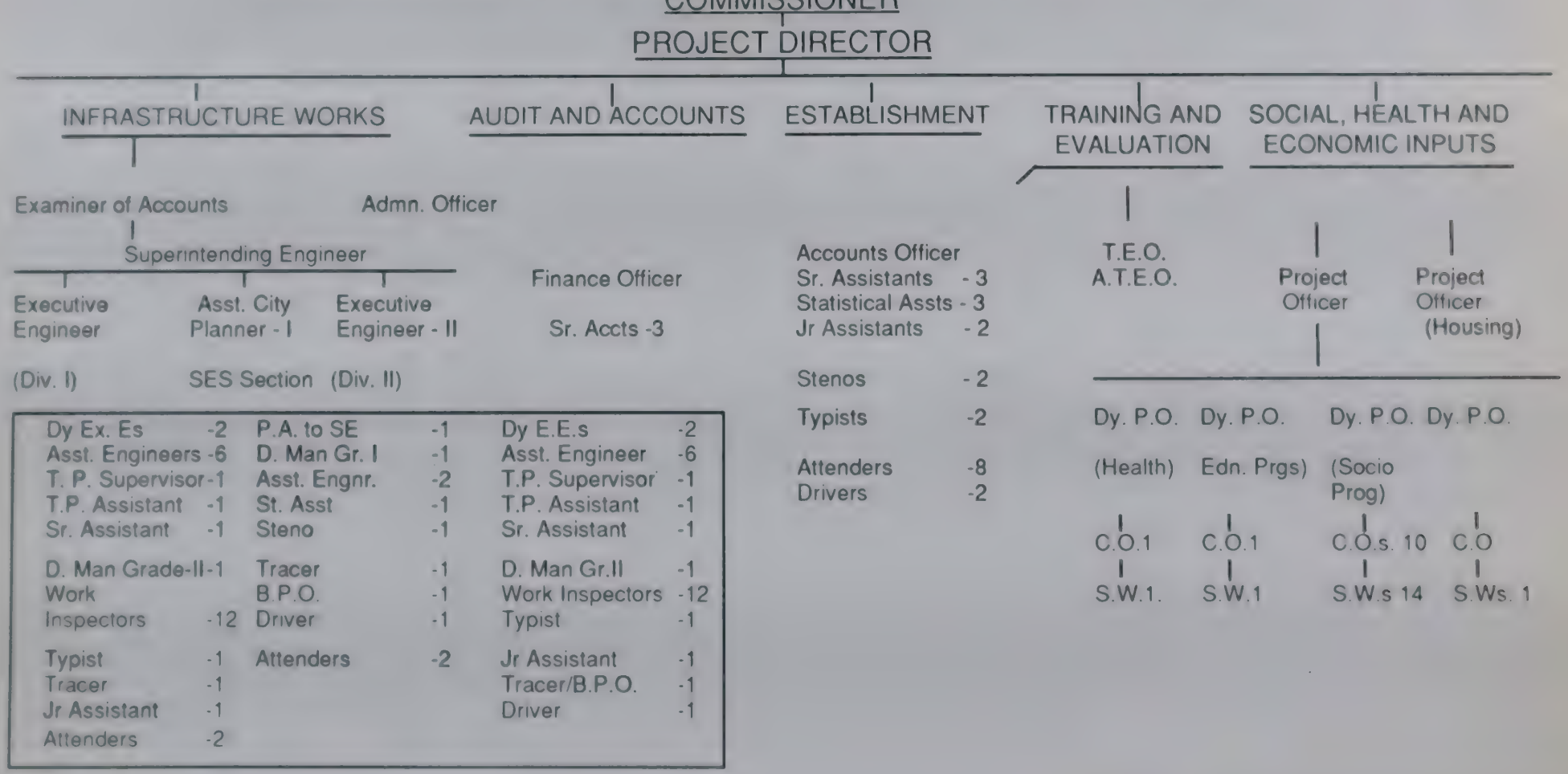
A. Organizational Structure:

The Organizational structure of the project can be considered under three categories - one is the formally appointed staff under the Visakhapatnam Slum Improvement Project of the Corporation; the second group is the semi-informal group of voluntary workers appointed under the project and paid a token honorarium who are selected from the local community side; the third category includes the entirely voluntary workers who are the Neighbourhood Committee members, mother leaders and others, not paid any honorarium.

The formally functioning staff consists of the Project Director working under the direct control of the Corporation Commissioner,with different wings working under him. The project Director directs five sections as shown in Figure.1.

Figure-1

VISAKHAPATNAM SLUM IMPROVEMENT PROJECT STAFF PATTERN



B. Work Distribution:

Briefly the nature of work distribution among the three different categories of functionaries is as follows:

i) *At the Community Level*: The community-based volunteers i.e. the Neighbourhood Committee members, guided by the Social Workers and Community Organizers of the Corporation mobilise the community to participate in and avail the benefits of the various health, socioeconomic, housing and engineering programmes. For this, they organize community meetings which the community organisers conduct with the help of audiovisual aids and technical personnel mobilized from the respective departments (for example, experts of the Food and Nutrition Centre of Government of India, Engineers and staff of the HUDCO, Teaching Staff of District Industries Centre). They organise the community to participate in the various training programmes,orientation programmes, health education and motivation activities.

ii) *At the Intermediate Level:* i.e. at the level of the Primary Health Centre, the honorary doctor and community health volunteer execute the curative and preventive programmes, in the individual slums.

iii) At the Corporation Level: The community organiser and social worker are involved in the initial community work to form the Committee, to assist them to generate awareness of services and participation in the services provided under the Project, and they are chiefly responsible for the execution of the various training programmes and vocational educational programmes at the the community level by liaising and arranging for the inputs of the respective departments. Similarly, in the case of the Engineering component, while the Neighbourhood Committee mobilizes the community for participation and maintenance of the community programmes and assets, the Engineering Departments of the Corporation is concerned with only execution of the work, after putting up budget proposals for sanction under the Project funds.

C. Leadership

i) At the Project (Corporation) Level: The leadership is chiefly provided by the Project Director and the Corporation Commissioner.

In the ODA assisted project, during the pre-implementation phase and early part of Phase-I, the leadership was provided by the Commissioner Mr K Raju under whose initiative, personal supervision and general administrative control the Project was initiated. Since August 1988, Mr S P Singh, has taken over and the Project implementation has been carried out well within the schedule. However, the day-to-day functions and progress of the project is coordinated under the overall leadership of the Project Director Mr U Subramaniam. The health programme has evolved under the guidance and initiative of Prof.B.Swarajya Lakshmi, Head of the Department of Preventive and Social Medicine of the Andhra Medical College. (She has since retired and is currently consultant to the Project). The supervision, and leadership as well as routine supplies and coordination of the PHC Centres is expected to be provided by the Deputy Project Officer (Health) who visits all the community health centres atleast once a month, provides drugs and supplies, and ensures the execution of the various health programmes. Monitoring of the health programme is being

done by the Monitoring and Evaluation officer who is also a public health physician deputed from the State Government to the Project.

ii) *At the Community Level:* At the community level, during the phase of community organization, the community organisers and the social workers have leadership roles in identifying members for the Neighbourhood Committees and sustaining these committees during the early stages. Following this, the Neighbourhood Committee President and members assume leadership roles for mobilizing the community and organizing the local activities.

PROCESS OF COMMUNITY PARTICIPATION

Community participation in the Visakhapatnam Slum Improvement Project can be identified to be taking place at three levels as follows: - The role of Neighbourhood Committees which are composed entirely of unpaid voluntay members of the community, the role of the Community Health Volunteer who belongs to the community, but to some extent selected by the Corporation authorities with some consideration for literacy (i.e. atleast 10th class pass and basic knowledge of health).They are paid an honorarium of Rs.500/- per month by the Corporation.They have a double accountability - to the Corporation on the one hand, and the community represented by the Neighbourhood Comittees on the other. Then, there is the role of the community at large which has to accept and utilise the government programme, maintain and properly utilise the movable community assets created under the scheme, and maintain community facilities like latrines, paying the costs of electricity for the community hall, etc.

A-Role of the Neighbourhood Committee:

The Neighbourhood COmmittee composed of about twenty members (male or female, literate or illiterate) are led by an elected president and treasurer. The Committee performs the primary roles of mobilizing the community as well as keeping a watch on the effective delivery of services by the semi-formal and formal functionaries of the Project. Their contribution to the Project is as follows:

i) About two to three members of each Neighbourhood Committee are also members of the Health Coordination Committee of the area. The Health Coordination Committee one for every PHC area is constituted by the doctor of the Primary Health Centre, the community organiser, sanitary inspector, Anganwadi teachers, assistant engineer, local Corporator, and the head master of the local government school, in addition to representatives of the Neighbourhood Committee. The Health Coordination Committee takes active part in ensuring that the community avails the immunization and other services provided by the primary health centre, and from the community side, ensures that the doctor and CHV conduct the clinic regularly. The sanitary inspector and other members provide advice on the prospective community activities towards promotion of health, which are carried out at the community level through the Neighbourhood Committee members. In response to the needs raised at these meetings, the sanitary inspector, Assistant Engineer, etc. put up detailed proposals to the Corporation for solving sanitation and other problems.

ii) The members of the Neighbourhood Committee actively take part in organizing the Mother Leader Programmes, ensure immunization coverage, antenatal

care coverage, motivation for family planning, identifying Dais active in the area for training, create awareness of health, mobilize interested persons to attend the group talks and programmes, etc.

iii) The Neighbourhood Committees ensure and assist in identifying the right candidates for training in the vocational training programmes, the proper beneficiaries for the bank loans and the HUDCO scheme which is meant for providing housing to the economically weaker section, and ensure that the benefits reach the proper persons.

iv) Each Neighbourhood Committee has a bank account opened by the Corporation, in which an initial Seed Capital of Rs.3000/- is credited and annual grant-in-aid is given for recurring expenditure. The Neighbourhood Committee administers this fund for the following purposes: The seed capital serves as a revolving fund from which small lumpsum loans are given to deserving persons to strengthen small business, improve income, or start a small business fo self employment. The Committee is expected to recover the money so far they have been to be able to recover about 25% of the loans and therefore recycling of revolving fund to other beneficiaries is not practically occuring in the slums.

From the annual grant-in-aid, salaries of balwadi teachers, sewing instructors and honorarium to other technical persons specifically invited for vocational training programmes are being paid.

v) Neighbourhood Committees are responsible to raise money from the community at the rate of Rs.2-3 per family per month, to pay the sweeper for the community latrine, the electricity bills and other such minor expenditure which has to be incurred on the community latrines, (community baths, community halls and other such facilities created under the project. It has been successfuly done so far. All the three community latrines and public baths which had to be constructed in three slums due to inadequate space for individual latrines for example, the Lakshmi Narayanapuram slum of ward number 34), are being maintained in good condition and utilized by the community.

vi) The Neighbourhood Committee is responsible to raise from the community, Rs.1000/- towards partial cost of the color TV for the community hall. During 1989-90, 30 color TV sets were installed on this basis. (During Phase I. black and white TVs and radios were installed). The community TVs and radios have been purchased on this basis for the community halls constructed under the first phase (1988-89).

vii) The Neighbourhood Comittee members are joint custodians for the community assets such as the TV sets and radio; the PHC medicines and equipments such as refrigerators provided for storing vaccines; minor equipment purchased for vocational training, such as sewing machines, black boards, etc. All these items are stored in the community hall, and Neighbourhood Committees members take responsibility for looking after the security of the items while they asre being used by the general public.

B. Role of Community Health Volunteer

The Community Health Volunteer is accountable to the Corporation to maintain records, to ensure coverage in the each of the preventive services, to assist in identifying the beneficiaries for the nutrition and other programmes, with

the Mother Leader Programmes, etc. She assists the doctor in conducting the clinic. On the community side she acts as a liaison to communicate the messages of immunization and family planning to the community and ensure their participation in these programmes.

C. Role of the COmmunity at Large:

i) Acceptance and Utilization of the services:

The utilization of services is quite high; as a result of the community coming forward for the various vocational training programme, at any given time, about 10-20 candidates are being trained in each community hall for TV and radio repairs. Under the vocational training programmes, many women have been trained in tailoring. Immunization coverage and family planning acceptance is quite high; mostly only trained dais' attendance during delivery is availed, and there is a high degree of awareness regarding these services. The community labour room facility has shown evidence of good utilization by the slum women. The community utilizes the recreational facilities provided in the community hall.

ii) The community has contributed partly towards the cost of items like TV sets, radio, and few minor equipments purchased for vocational training. 30 community color television sets have been installed on this basis. The Neighbourhood Committees mobilized Rs.1000/- from the slum dwellers, and the rest was contributed by the Municipal Corporation.

iii) In slums where community latrines have been constructed, each family is contributing Rs.2-3 per month towards salary of the sweeper and other maintenance costs.

iv) Housing programme is well accepted by the community and families which take up house construction are carrying out timely activities to complete preliminary work and expenditure which they have to incur, before they become eligible to receive the remaining 75% of HUDCO loan to complete the construction.

RESULTS

The results of the VSIP owe a great deal to the activities initiated prior to the Project as indicated in sections I and III. Against this background, the result in terms of infrastructural inputs, socio-economic development as well as health and family welfare indicators are presented below:

A. Health:

i) *Infrastructure and Staff*: Thirty-two primary health care centres have been established and twentyfive honorary doctors have been appointed to look after the centres. In addition to the 18 ANMs who are already appointed under the ICDS scheme, 12 additional ANMs have been appointed to provide services and supervision for the CHVs,one ANM for every about 5000 population. Twenty eight candidates were selected and trained as community health volunteers.

ii) *Health Awareness and Utilization of Services:* The number of daily new outpatients in the PHC Centres and the immunization coverage rates of about 83% for the pregnant women, and approximately 90% for the target group children, indicate that the utilization of services from the PHCs is very good.

iii) *Family Planning Acceptance:* Family planning acceptance has been improving. Eligible couple protection rates by sterilization is of the order of about 50-60% in most of the slums.

iv) All the slum dwellers appears to be aware of the needs for safe delivery services. The community labour room commissioned in January 1989, has been very popular as a place to undergo delivery by trained dais, among mothers of the slums.

v) Under the VSIP about 135 dais who were untrained, underwent training.

vi) Large number of mother leader training programmes were held as well as food and nutrition training programmes. Large number of Clean Hut Competition have resulted in a general prevalence of neatness and clean atmosphere in the slums.

vii) The honorary doctors, COs, etc. strongly felt that nutritional levels of mothers and children was much better compared with what it was five years ago and that the children looked much healthier.

viii) Under the Childhood Disability Management Programmes, about 800 children were detected and suitable rehabilitation was arranged for them through the involvement of the Andhra Medical College, and several voluntary agencies.

ix) An atmosphere of cleanliness and neatness is visible, not only in the surroundings and roads, and maintenance of dustbins but also in terms of general appearance of the people, personal cleanliness and home maintenance.

Due to the involvement of the men folk in the Neighbourhood Committee, substantial community activity, and the general environmental improvement, a certain value of respectability and dignity among the families has been growing. Social evils such as alcoholism, child and wife abuse, are gradually decreasing owing to the social and economic implications of leading a better quality of life, the economic compulsions of the need to repay housing loans to the HUDCO, and the compulsions to repay loans given for income generation activities.

x) So far under the housing scheme, about 5000 houses have been constructed. Approach roads have been constructed and also systematic open drainage, which has resulted in a greatly improved atmosphere.

C. Socioeconomic Development:

Socioeconomic development can only be assessed by a much more extensive survey. However, during the visits to the slums, it was observed that most slum households were living in pucca and semi pucca housings; many households had amenities such as television, radios, etc. and apparently these were the same families which had been living hand-to-mouth existence prior to the project.

COLLABORATION AND CONFLICTS

The Visakhapatnam Slum Improvement Project has been based on a principle of collaboration with as many agencies as possible, to utilise and offer the use of complementary resources at the disposal of governmental agencies with extension services, and voluntary agencies. In cases where the other agencies

need certain facilities from the Corporation, the Corporation offered the use of its infrastructure, and where, the other agencies had complementary services, the Corporation utilised them for achieving the objectives of the Project. The prominent agencies with which a continued programme of collaboration exists are as follows:

i) *Involvement of Private Practitioners:*

This is one of the most striking feature of the project and results could be assessed only in the long term after it has been in operation for some time. A local private practitioner has been selected for every five hundred to thousand families paying them a honorarium of Rs.1000/- per month to provide free medical and preventive services for three hours a day. The Corporation provides drugs for use at the Centre, and vaccines are provided for immunization. So far, the experience has been, that the honorary doctors attend the clinic quite regularly. In cases where they do not attend regularly, the Health Coordination Committee consisting of a few Neighbourhood Committee members, Community Organizer, and the Honorary doctor, at the monthly meeting, discuss the matter and the members bring it to the notice of Corporation Health Officer and other authorities. This results in some kind of monitoring system to ensure availability of the doctor.

2. *Involvement of the Andhra Medical College - Preventive and Social Medicine Department:*

a) The Preventive and Social Medicine Department of the Andhra Medical College has been all along consulted and respected in an Advisory capacity to advise upon the plan of the health programme and its execution.

b) During the UNICEF project phase and also subsequently, the CHVs, the Community Organizers and the social workers were trained by the Department of PSM to identify disabled children in the slums and motivate their families to take these children for the rehabilitation programmes organised by the UCD Department under the Childhood Disability Management Programme. Thereafter, the identified children were screened by the final year medical students and interns posted to the P & SM Department under the ROME (Reorientation of Medical Education) Programme, before being referred to the teaching hospital of the Medical College.

c) The P & SM Department was chiefly responsible for planning and executing the "Base line' health survey to provide feed back to the planners of the ODA assisted project.

d) The faculty of the Department take active part in teaching and training of the community health volunteers and in the other programmes conducted in the community, like the Mother Leader Programmes and Nutrition Education Programmes. The department also provides orientation training programme in Preventive Medicine to the honorary doctors appointed under the project.

e) The Universal Immunization Programme of Visakhapatnam city is entirely guided by the P & SM Department. Prior to adopting the Fixed Centre Approach the Department had formed 32 immunization teams involving the doctors and staff of the Municipal Corporation, the King George Hospital, Visakhapatnam General Hospital, the RFWTC, ICDS, Directorate of Medical and Health Services,

and also the staff and faculty of the Andhra Medical College, which resulted in very high levels of coverage of children and antenatal mothers for immunization. The details of inter-agency collaboration are given in Table:

f) In addition, the Medical College P & SM Department is responsible for storage of vaccine during the immunization drive, provides vehicles, provides training to immunization team members, and previously used to guide the enumeration survey and conduct of immunization campaign.

3. *Involvement of the College of Nursing*

The College of Nursing has volunteered to organise practical training of dais at the Community Labour Room after the theory and practical training at the School of Nursing which has been going on since the UNICEF assisted programme began. The College also provide staff in the form of final year Nursing College Students to man the community labour rooms, which have been constructed in the neighbourhood of slums situated on the outskirts of the city .The students are posted round the clock. Along with this, the students are involved in the immunization and other health programmes of the neighbouring slums. The College of Nursing tutors also provide supportive emergency call services in case a trained dai or student has difficulty in carrying out a delivery in the community labour room.

4. *The Food and Nutrition Centre of the Government of India:*

Based in the Andhra University Campus,the Centre is chiefly responsible to provide staff to conduct the five day Food and Nutrition training programme for the slum population. The training programme is organised by the Project functionaries and the Neighbourhood Committee, and taught by the Nutrition Centres Staff.

5. *The Gremaltes Leprosy Mission:*

The Gremaltes organization has been active in Visakhapatnam to detect leprosy cases and treat them towards control of the disease. The basic strategy involves community involvement and education for early detection, successful treatment completion and rehabilitation of leprosy victims economically and socially in the community. The Project functionaries of the Corporation inform the Leprosy Mission in advance, of the schedule of dates of the Mother Leader Programmes, the Food and Nutrition Training Programmes, any other group talks and film shows, so that the Leprosy Mission workers take advantage of the programme to educate the people on leprosy. The primary health centres which are being run in the community halls are also utilised as an outlet for drug distribution for leprosy treatment.

6. Collaboration with the Housing and Urban Development Corporation *(HUDCO)*

One of the major objectives of the Project is to enable the HUDCO programme to be successful in the slums through the proper utilization of the community organization and structures created by the UCD department activities since inception in 1979. As a result of this, it is expected that the HUDCO would be able to execute timely construction of about five thousand houses per year in

Table - 4

DETAILS OF INTER-AGENCY COLLABORATION

Agencies Involved	PERSONNEL						EQUIPMENT					
	Survey staff	Immuni-zation teams	Super-visory Doctors	Moti-vation team	Publi-city	Trai-nings	Syri-nges and Needles	Vaccine-career	Steri-lizat-ion Bins	Emer-gency drugs	Publi-city	Vehicles
Municipal Corporation	32	36	4	64	100	4	200	20	-	-	100%	4
King George Hospital	14	14	4	-	-	4	500	-	32	-	-	1
Visakhapatnam General Hospital	5	6	2	-	-	2	-	-	-	-	-	-
Rural Family Welfare and Training Centre	4	4	1	-	-	1	-	-	-	-	-	-
I C D S	6	4	1	-	100	1	-	-	-	-	-	1
D.M. & E.D.	1	-	1	-	-	1	1200	-	-	-	-	1
Andhra Medical College	40	-	5	-	-	5	500	12	-	15000	-	3
	102	64	18	64	100	19	2400	32	32	15000	100%	10

the slums Visakhapatnam without undue delay. It is expected that by the end of the Project, approximately Rs.30 crores would have been spent by the HUDCO on the subsidised loan housing scheme in the slums in the city. Identification of the beneficiaries, ensuring the people's participation and action to get good houses constructed, are some of the collaborative functions performed by the Project.

However, the ability of the community organization to ensure timely repayment of the loans to the HUDCO through persuasion and social action, remains to be seen in the future.

7. *Collaboration with the Nationalised Banks:*

The nationalised banks extension services departments avail the services of the community organization structures of the Project, and get the information regarding vocational training and to identify appropriate beneficiaries to provide a suitable loan for them.

8. *Collaboration with the District Industrial Centre:*

The District Industries Centre has extension functions to provide training in certain skills and technical expertise to enable the poor for self employment. The DIC is invited by the Project functionaries to carry out vocational training programme at the community halls constructed under the Project. Suitable trainees for the various types of programmes are identified by the Neighbourhood Committee, the Community Organizers and social workers.

9. *Collaboration with Other Voluntary Agencies*

Several voluntary agencies like HERU sponsored by the ODA-UK and others have active links with the Project in rehabilitation of disabled children in the slums. Voluntary organizations like the Visakhapatnam Navanirman Sangha and others, which are involved in adult literacy, etc., which experience difficulties due to lack of infrastructure and lack of adequate base in the community for drawing participants to their programmes, are offered infrastructural facilities of the community hall, the assistance of the Neighbourhood Committee and their involvement to educate the community for these programmes. In addition all organizations active in area, whatever their activity of interest, are kept informed well in advance, of the schedule of community training programmes to be carried out so they can also attend and impart their messages, taking advantage of an audience generated for the Project Programmes.

The Municipal Corporation involved the Sulabh International to provision of sanitation, particularly in construction and maintenance of community latrines and baths which were taken up in the VSIP. As a result of Sulabh's involvement, the community has been successfully maintaining them in good and viable condition.

B. Conflicts and Constraints:

i) Initially when the project began, since it involved channelising substantial funds for housing and other aspects, there was a tendency for the local influential and relatively better-off leaders to attempt to corner the benefits. However, the

sustained strategy of ensuring that every Neighbourhood Committees member should be selected from every consecutive houses, ensured that in principle, the existing power structures did not corner the benefits.

2.) While the utilization of services and participation in the health programmes is good, the participation in the socioeconomic and housing programmes is chiefly in the form of availing services. The Neighbourhood Committees have not so far taken over successfully, tasks like, repayment of loans, recycling the funds, etc. The community has been largely accepting the loans and subsidies. A vigorous effort would be needed to make it repayable.

3) Some degree of constraint is felt with regard to the need for increasing involvement in Primary Health Care, of the private pracctitioners who have been appointed as honorary primary health care doctors, especially in the context of the need for a shift of focus from primarily curative orientation, to preventive and promotive programmes. So far under the Project, honorary doctors have been providing only curative and immunization services. Under the primary health care programme, keeping in view the rampant problems of malaria, filariasis and diarrhoeal diseases, systematic community-based control programmes in line with the principles and activities laid down under the national programmes for these diseases, has not yet taken off.

4) It is reported that many doctors feel that the honorarium of Rs.1000/- is not adequate and that it should be increased; resistance is being articulated in view of the increasing responsibilities for community health, such as supervision over CHVs and ANMs that is now being expectd of them, and their expected involvement in validating and supervising the documentation now being done by the CHVs and ANMs on the family health profiles. Their response and involvement can only be assessed in the future.

5. By and large, no conflicts have been experienced with other voluntary agencies operating in the area.

FINANCIAL RESOURCES AND EXPENDITURE

The Visakhapatnam Slum Improvement Project has been started entirely with ODA assistance with a total project outlay of Rs.21 crores to be spent over a period of 3 years. This includes the payment of salaries for staff of the UCD department working on the project, and honorarium paid to the workers appointed under the project. Out of Rs.21 crores, about 80% has been allocated for development of civic infrastructure. For health and social inputs, the allocation is Rs.2 crores over a period of three years. Table 2 presents a broad picture of the financial outlay of the Project.

It may be noted that directly under the Project, approximately Rs.2000/- per capita is being spent or about Rs.10,000 per household. It may also be noted that the establishment cost works out to about 6% of the total project cost.

While the sum of Rs 21 crores is envisaged under the Project itself, as a result of the coordination of the VSIP with the HUDCO, the banks and other financing agencies to channelize funds to the appropriate beneficiaries, it is expected that the total financial inputs from all agencies would amount to about Rs.60-65

crores. This works out to approximately Rs.30,000/- per family being invested for all-round development.

It was noted that for immunization the additional cost on account of UIP activities worked out to Rs.5/- per child immunized.

It was noted that the expenditure on Primary Health Centres is quite substantial having been more than Rs.14 lakhs for a population of about 50,000 covered during the year. The Deputy Project Officer (Health) estimated that approximately Rs.1000/- perr Primary Health Centre per month is the budget for drug along, which works out to Rs.12,000/- per PHC per year (for a population of about 5000).

FACTORS IN THE SUCCESS OF THE PROJECT AND CONSTRAINTS

A.OrganizationalFactors

i) The success of a programme of health and community development implemented with community participation through the government sector, has been largely due to the initial leadership of the UCD department provided by Mr and Mrs D G Rama Rao, and the commitment of the Municipal Corporation to maintain community participation as a vital component of any programme initiated under the UCD Department. Following the establishment of this tradition in the beginning of the UCD activities, the commitment could be crystalised in the form of an organizational structure oriented to community organization and development. This structure which is rather unique for municipal corporations (and other governmental departments), consists of the concept of community organisers and social workers who form the core staff of the Department. The procedure of preceding developmental activities with community organisation by these staff was firmly establised during the UNICEF assisted project period. Subsequently when the Visakhapatanam Slum Improvement Project with ODA assistance was started, the same tradition and procedures continued.

ii) The sustained track record of fostering community participation in the government programmes both under UNICEF and ODA assistance, can also be attributed to maintenance of good leadership in the project, although the persons occupying the posts of Commissioner and Project Director were changed. Mr K Raju who was the Commissioner during the pre-implementation and early implementation phases of the project was replaced by Mr S P Singh. For the ODA-Project, the project director Mr U Subramaniam was appointed. Through all these changes, leadership inputs to the project and commitment to slum development have remained of a high order, at the top level of administration of the corporation.

iii) Another major factor for the remarkable change brought about in the slums has been, the active collaboration solicited and nurtured by the UCD Department with various agencies, governmental and non-governmental, resulting in much greater success than each agency could have achieved in isolation. The collaboration between the Project, housing agencies, banks, District Industrial Centre, etc., resulted in mobilization of community participation for all the programmes.

iv *The project leaders felt that one of the major reasons for the success of the slum improvement project in Visakhapatnam, under the UCD department was*

that, the Municipal Corporation, at its very inception (when the City population crosssed one lakh in 1979 and slum population was about 20-25 thousand), had incorpo rated in its structure and programmes a planned approach to solve the problems of the slums from this stage itself. This, the Project Director feels, has enabled a phased and systematic approach to development of slums, rather than adopting the usual policy (or lack of policy) of neglect of slum problems, which characterises the administrations of most Municipal Corporations. Most Corporations allow slums to grow both in extent and density of population without civic amenities till a very late date, until the city grows irrevocably in a haphazard manner, the slums become almost unmanageable, and the extent of problem becomes too huge to handle. This type of eventuality was averted by having policies and programmes for slum development at the very beginning.

v) The Project Director felt that the relatively small size of Visakhapatnam city and its population resulted in quite a manageable situation to approach the problem of slum development. Thus enough land could be mobilized and the department could cope up organizationally, to rehabilitate the slum dwellers.

vi) Another important aspect which was felt to be a real asset to the Visakhapatnam Municipal Corporation was the integrated organizational structure and hierarchy, bringing all concerned departments under the UCD Department. Thus all related departments were brought under one head and one roof. That is, the sanitary inspectors responsible for the slums, the health wing, the engineering wing are all located in the same building, and organizationally, they are administered under the Urban Community Development Department. This has enabled the officers and other lower level officials concerned, to have timely coordination, and resolve conflicts and problems at an almost a intra-departmental level. Otherwise multisectoral activities in the Government sector usually turn out to be an elaborate exercise in interdepartmental coordination, even for small matters, resulting more delays in and paperwork,rather than programme execution.

vii) A firm policy was adopted by the Municipal Corporation to select the candidates for the position of COs, social workers and CHVs, based on merit and community organization capability without compromising on quality of manpower recruited. Inspite of substantial local and political pressures,committed manpower was recruited. This resulted in formation of a hardworking and sincere project team.

viii) **Monitoring and Supervision**. There appears to substantial provision for adequate monitoring and supervision of the various functionaries, prompt provision of supplies and follow-up of progress on a day-to-day basis, under this Project Monitoring and supervision have been quite intensive during the ODA-assisted project phase In addition to adequate mobility of project officers and staff to the field ensured through adequate number of vehicles and POL budgets, the frequent visits and close folow-up by the overseas ODA agency almost on a month to month basis also appears to be one of the factors in maintenance of high degree of coordinated activity, supervision and monitoring that is necessary, atleast initially, in a programme where accountability is sought from semi-formal and informal functionaries (as described in section 7)

B .Financial Input Factors

A very important feature which, the project officers also feel, has influenced the degree of community participation, is the substantial financial inputs and expenditure which have been incurred by the government in the Project area.

During the period of UNICEF-assisted MCH project, provision of supplementary nutrition to children and pregnant mothers did act as an incentive to mothers to participate in the programme and draw the rest of the community into the MCH programme. Under the ODA assisted project beginning 1988-89, the financial input in the project area towards tangible benefits and assistance like housing and other inputs, has been quite substantial, approximately Rs.30,000/- per household on an average (as per the estimates of the Project Director).

Thus, linking these inputs with health and family welfare inputs, was also to a large extent instrumental in drawing the community participation in the health programmes.

C. *Strategy Factors*

i) The strategy of linking health inputs with socio-economic inputs and housing, under one roof, resulted in objectives other than the primary objectives of the UCD department also being fulfilled. For instance, during the intensive family welfare drive of 1988-89, the close feedback which was possible between the health functionaries and other agencies involved in economic development, like the banks, resulted in the ability of UCD Department to effectively use the socioeconomic inputs as a incentive for family planning acceptance. On the other hand, the community-based Neighbourhood Committees and Community Health Volunteer scheme which come into existence for health purposes, could be utilized by the other development agencies like bamks, housing agency (HUDCO), and others, to make their own programmes a people's programmes, without having to duplicate the community organization efforts which had already been made under the health-MCH programme between 1982-86.

ii) One of the most prominent features of this project is the collaboration with other apex health institutions like medical colleges, whose P & SM department's public health expertise was effectively utilised by the municipal corporation to mobilize the skills required for systematically organizing the immunization and family planning drives, the Childhood Disability Management programme, effective training of CHV's and Dais,etc.,in an urban setting. The utilization of services of the Food and Nutrition Centre of Government of India, College of Nursing and other major hospitals, resulted in a situation wherein the Municipal Corpora tion did not have to duplicate the staff, skills and expertise required for the activities carried out under the UCD-VSIP project.

D .Community Factors

The existence of a well-organised functioning structure of Neighbourhood Committees with broad-based community representation which had already been functioning for five to six years prior to the start of the ODA assisted Project, on account of the MCH programme assisted by UNICEF, created a fertile ground for initiating an integrated development programme with community participa-tion.

CONSTRAINTS AND GAPS IN PROJECT IMPLEMENTATION

i) The chief role of honorary doctors has been to provide curative services, though it was originally envisaged that they would assume more and more preventive roles. While they have accepted their role of teachers in health

education programmes, the Deputy Project Officer (Health) felt that it is increasingly expected that they perform more preventive roles, more home visiting for domiciliary services and preventive work, assume responsibility for proper documentation of community health profiles, provide guidance to the community health volunteer in understanding and maintaining population health profile, periodic reporting to the UCD Department, etc. There was resentment from the honorary doctor to take up these additional responsibilities and many of the doctors had expressed that the honorarium of Rs.1000/- was not commensurate with these responsibilities.

ii)While a good viable infrastructure has been created in the form of community staff and honorary doctors, who do not place much demand on the Corporation resources in terms of recurring expenditure (salaries and other staff over-heads), the content of the primary health care programmes needs greater attention, now that the health system for the slums has been set up. It is known that there is a high prevalence of malaria, filariasis, diarrhoeal diseases.Well-established principles, mechanisms and manuals for implementation of Control Programmes are of these diseases in operation in the rural areas. Considering the high degrees of community awareness and community development infrastructure that has already been built up,orientation of the health staff to implement these programmes could result in better utilization of the health system for primary health care and disease control.

iii) One of the important aspects of the VSIP project to which health service researchers would look enthusiastically for results, is the degree of success in documentation of community health profiles monitoring, and timely utilization of data in delivering health care. Family health folder system has been introduced and is expected to be maintained by the community health volunteers. It is quite ambitious in the scope of information it seeks to provide to decision-makers. However, it appears that inspite of the CHVs being selected from the community and trained, comprehension of the contents of folder and of the serious need for documentation, which are prerequisites for any monitoring system to be a success, are yet to be adequately built up. Nevertheless, on scrutinizing some of the family folders at the Primary Health Centre, Indiranagar - II and a few monthly reports furnished by the CHVs to the Municipal Corporation, it was felt that, with time and effort it may be possible for a government organization to strengthen the reliability of the data that flows from grass root level to the monitoring agency, (in this case the UCD Department).

On the other hand, another feature which needs strengthening if the monitoring system is to be meaningful is, utilization of whatever data is available and reliable. This aspect needs further effort on the part of the health and project administrators. Even though a lot of simple data can be extracted from the information being currently furnished in the monthly reports, owing to some problem with the computer at headquarters, even available data was not really available to the health officer or the Project Director in proper form to guide them in making decisions.

Thus monitoring system needs strengthening both from the grass root level and the UCD level if it is to serve as an exciting feasible model for application in other parts of the country.

LEARNINGS FROM THE PROJECT

The UCD Department which has carried out community development work in the slums of Visakhapatnam has viable learnings for the staff of government departments across the country, which are being exhorted to elicit comunity participation in all the socioeconomic, health and development programmes.

i) One of the most important learnings from this project, is the potential value of creating an organizational structure exclusively for community organization whose activities are then coordinated with the programmes of other sectors like health,

housing, socioeconomic inputs, etc. If this system is properly staffed with the right type of people, and monitored, it can result in a situation wherein the government programme personnel can elicit community participation for the government programmes, as shown in this Project. In fact it was expressed, by the Project leaders, that more than the involvement of the health staff - i.e. the doctors and ANMs,the success of most of the health programmes including family planning, was due to the involvement of the community organizers, the social workers and the community health volunteers.

ii) In the UCD department project, the leaders had a clear perception of the organizational level up to which the activities of the different sectors like housing, bank loans for economically weaker sections, health, social welfare, vocational training, etc.can be and need to be coordinated under a single administrative head. This is one of the strengths of the project.

Thus while the HUDCO, banks, engineering department of the Corporation and other agences maintain their separate departmental identity, their own administraion, budgetting, etc., the activities of each of these departments at the grass root level has been recognised to be of overlapping nature. The need to be linked to each other so that they should make sense in the context of community development, (for example linking type of loan to the type of vocational training undergone), was reflected in bringing all activities under the umbrella of the UCD Department. Bringing the operations of these different agencies under the coordination agency that is the UCD, either directly, (refer organizational structure table), or through the coordination committees, loan sanctioning committees, etc, which contained representatives of every programme, resulted in proper utilization of the financial outlay spent under the project.

iii) Another important learning from this project is that the same community structue that is built up for one programme can be utilized by the other developmental agencies without having to duplicate the staff, skills and budget needed for developing community-based participative structures for participation in each of the developmental programmes.

iv) Keeping in view the complexities of organizing a health care programme in cities, the effective utilization of the apex bodies like the Medical College, College of Nursing, etc., for the organizational skills and training facilities, is another valuable learning from this project. Considering that there are more than 120 medical colleges in the country mostly located in larger cities and towns, they can prove a valuable asset to municipal administrators as shown by the experience of the Visakhapatanam Project.

v) The coordination between the government and voluntary agencies has been considerable and no doubt, this is one of the reasons for the success of the Project. The exact contribution and impact of such a coordination would need detailed study.

vi) While substantial participation by the community is evident, the next phase of community mobilization would need to concentrate on transferring gradually more and more responsibility to them. Even to inculcate a sense of responsibility in the community on the value of loan repayment so as to make it available again to othe needy persons, would need much consolidated effort in the slums by the COs and other staff of the UCD. There would need to be a concentrated effort without dilution of effort in too many activities in too many slums at the same time. Similarly the community would need to mobilize its own resources for several improvement activities rather than await government subsidies and loans.

vii) Given the complex and difficult task of coordinating many sectors especially involving different categories of technical personnel, the role of a strong integrated leadership cannot be underestimated. Leadership skills and qualities need to be developed in administrators who are called upon to administer multisectoral programmes.

The success achieved under the UCD Department of Visakhapatanam shows that it is possible to elicit community participation through government organization, and it should serve as a model and inspiration to study the organizational structure,monitoring systems, leadership and other aspects, which have possibly contributed to the success of the project so that similar principles of administration could be replicated in other situations for implementation of multisectoral developmental programmes.

Table - 2

VISAKHAPATNAM SLUM IMPROVEMENT PROJECT
(WITH ODA ASSISTANCE)

Particulars	I Phase (1988-89)	II Phase (1989-90)	III Phase (1990-91)	Total
No. of Slums	45	60	65	170
Total Population	63,000	64,000	64,000	1.91 lakhs
Total Project Cost	Rs.5.39 Crores	Rs.6.50 Crores	Rs.8.81 Crores	Rs.20.70 Crores
Civic Infrastructure	Rs.4.11 Crores	Rs.4.94 Crores	Rs.6.62 Crores	Rs.15.67 Crores
Health and Social Inputs	Rs.50.37 lakhs	Rs.67.08 lakhs	Rs.91.12 lakhs	Rs.2.08 crores
Establishment	Rs.28.61 lakhs	Rs.50.00 lakhs	Rs.50.00 lakhs	Rs.1.28 Crores
Machinery & Training Costs	Rs.49.59 lakhs			Rs.49.59 lakhs

COMMUNITY PARTICIPATION IN HEALTH AND FAMILY WELFARE: INNOVATIVE EXPERIENCES IN INDIA

A must for every Health Administrator, Planner and Professional

Indian Society of Health Administrators (ISHA), Bangalore is a premier society of medical and non-medical professionals, established in 1979 to bridge the gap between the actual and desirable state of health services in India through professional development of health personnel. It has 25 Regional Offices, large membership of individuals and institutions; organizes annual conferences; training programmes at national, state and institutional levels; engages in research leading to policy formulation and effective programme management; provides consultancy services to national and international organizations, and Central and State Governments; publishes the Journal "Health Administrator", guidebooks, and reports to professionalize health systems and contribute towards professional development of health personnel. Plans are underway to start a full-time Post Graduate Programme and correspondence programme in "Health and Hospital Administration".

The importance of community participation in health and developmental programmes had been emphasized by the Bhore Committee prior to Independence, and later by the Government of India right from the first Five Year Plan through the Seventh Plan, and now receiving renewed emphasis in the Eighth Five Year Plan.

How do we draw the participation of the community into health and developmental programmes? What are the processes involved? What are the critical factors for successful community participation in health, family welfare and development, given the wide variety of contexts – urban, rural, tribal, poverty-prone villages, slums, organized - unorganized sectors, so on?

To understand these aspects, ISHA conducted a study of nineteen innovative projects by voluntary and government agencies where the community was successfully drawn into and participated in the programmes.

This Book presents case studies and learnings from these projects. ISHA hopes this Book will serve as a guide to policy makers, health administrators, professionals, and programme officers in planning and implementing effective community participation process for community development.